Manual for Health Visitors

AND

Infant Welfare Workers.

MRS. ENID EVE

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Manual for Health Visitors

AND

Infant Welfare Workers.

BY

SEVERAL WRITERS.

EDITED BY

MRS. ENID EVE,

Late Ministry of Health, formerly Chief Health Visitor and Sanitary Inspector to the Metropolitan Borough of Holborn.

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MCMXXI

TO THE MEMORY OF THE

LATE COUNCILLOR WALTER HAZELL, J.P.

THIS BOOK IS DEDICATED.

Who by his ever open purse and his ever ready sympathy did everything in his power to realize his own ideal of making Holborn the "Model for the World" in Infant Welfare work, 1907-1919.

By whose bounty many infant lives have been saved and who was an example for all Councillors in that he recognized and esteemed as honourable the work of a Health Visitor.

PREFACE.

IT is with much pleasure that I accept the invitation to write the preface to "The Manual for Health Visitors," largely because I have been so closely associated with the evolution and development of the work of these indispensable officials. It is nearly twenty years since I first became convinced of the necessity of such appointments if further advance was to be made in the improvement of the health of the nation. When the twentieth century dawned great improvement was to be observed in the general death-rate, caused to some extent at least by the better removal of nuisances, improvement in water supplies, &c., but probably to a still greater extent by the better food supply and higher wages of the working classes. A closer examination of statistics showed however that there had been practically no improvement in the infantile death-rate and that therefore the causes which made for the great slaughter of infants had not yet been touched. To some of us in active public health work at this time, this seemed to point to the fact that the home was the chief factor, and if advance was to be made something must be done to stir the conscience of, and educate the mother as to her real duties to her children. If this be so (and facts appear to prove it) obviously the work of dealing with the mother inside the home must be carried out by women, who hitherto had had no definite place in the public health service—hence the origin of the health visitor in the modern sense. It is a fact that in one or two London and Provincial areas, women inspectors had been appointed for special duties of inspection, and had done good

work, and though they carried out certain work now performed by health visitors their duties were not specially associated with the home and the infant. Here I feel constrained to say a few words about official titles. From the earliest days I have set my face dead against the association of inspectorial work with health visitors' functions. I have long ago protested against the title of Lady Sanitary Inspector. The lady I take for granted, and to my mind and in my experience too, the inspectorial idea is bad, both for the official and her work. My practice has been to instil into the minds of my own staff that they go to the house as a friend of the family and not merely to find causes for reproach. The question of status, official power and emoluments can all be met, as they have been to some extent already, by proper enactment, and there is no reason why an unsuitable title should be perpetuated. I know many do not like the title "health visitor," but nobody yet appears to have discovered one equally expressive and unobjectionable.

A question now occupying the minds of the profession and others interested, is that of education. The Ministry of Health has recently evolved a scheme which has evoked a good deal of criticism, but one which speaking generally I distinctly favour. I believe it to be desirable that the health visitor should be highly educated in general subjects, and should commence her professional training early. I am quite aware of the difficulties of employment of young health visitors and that probably there will be a hiatus between the completion of her training as such and her obtaining an official appointment, but so important do I consider early special training that I think means must be found to deal with the newly qualified. It is obvious that there must be a large increase in the number of women workers and probationary work will probably be available under a larger and improved scheme. It is the custom in certain areas at the present time to appoint trained nurses as

health visitors, and some of my colleagues hold the view that a fully trained nurse makes a right type of health visitor. From this I entirely dissent. In saying this I have not the slightest wish to minimize the value of the nurse's work. I give way to no one in holding her self-denying labours in the highest esteem, but I am convinced by long experience that the training of a nurse, not only does not fit her, but actually to some extent unfits her for the best performance of a health visitor's duty. The idea of her (the nurse's) suitability has probably arisen from the fact that in many districts a health visitor's work consists only in looking after infants and working at infant welfare centres. For long I have held the view that not only from the point of view of the work, but also from that of the health visitor, her duties should be varied and it was on account of this that I instituted a conjoint appointment of so-called health visitor, school nurse, tuberculosis visitor and midwife inspector. Experience has shown me that the practice is correct and absolutely necessary in county areas. From the point of view of the work, it is desirable that the number of persons visiting the home should be limited, so that the mother particularly should not be unduly worried. Travelling too is reduced if one woman in an area is capable of dealing with all varieties of home health work, while the soul-chilling effect of dull routine is lessened by the larger sympathy engendered by increased scope of work. A health visitor should therefore in my opinion be fitted to undertake in her own person, all types of work stated above.

I think I ought to give a caution to those who desire to become health visitors. The work is hard and exacting. It is hard physically and no one who is not strong should think of taking it up. It is often trying to the temper and those with irritable dispositions are not likely to succeed, but at the same time, the well qualified, strong and well-balanced woman, has opportunities for good given to few. In modern social conditions the

health visitor is no longer a luxury, she is an absolute necessity and as the science of hygiene progresses, year by year her work will gain in importance until she becomes in the public eye, one of the most important officials in the sanitary service. This being so, it is obviously desirable that help should be given to those who desire to qualify themselves, and it is with the greatest pleasure that I commend this Manual, written as it is by those whose knowledge and experience pre-eminently fit them to act as guides along a difficult path.

A. Bostock Hill.

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MANUAL FOR HEALTH VISITORS AND INFANT WELFARE WORKERS.

INTRODUCTION.

Origin and Evolution of Health Visitor.

It is twenty-seven years ago since the first woman sanitary inspector, the percursor of the health visitor, was appointed in England.

The Borough of Islington in 1893, was the first public health authority in London to appoint a woman sanitary inspector with full legal status.

Prior to this, the city of Nottingham in 1892 had appointed a woman workshop inspector; and Kensington also in 1893 appointed two women sanitary inspectors to inspect laundries only at first and later workshops where women were employed.

Still earlier, in 1870, the City Council of Glasgow appointed four "female visitors" (afterwards known as assistant sanitary inspectors), to advise the inhabitants of tenement houses how to keep their dwellings clean and sanitary. They had the same right of entry as the men sanitary inspectors and were enabled to deal with some nuisances directly.

By 1901 there were eleven women sanitary inspectors in London. By 1905 official infant visiting was beginning to be adopted by London boroughs and other towns, and although the bulk of this work was at that time carried out by the women sanitary inspectors, yet a new class of official known as the health visitor was beginning to be appointed in increasing numbers in various parts of England.

The city of Birmingham appointed health visitors first in 1899. The first women in England to be called by that name were those employed prior to this by a

voluntary health society in Manchester, who were women of little education employed to visit working class homes and talk on health matters and cleanliness to the inmates. Partly for this reason the title was disliked by women public health workers at the time.

The name was introduced partly to show the differentiation of duties which had now become necessary partly owing to a mistaken notion that the word inspector was offensive to the people visited, and last but not least in order to give local authorities the opportunity of substantially reducing the salary! Wherever a woman inspector was already employed and subsequently the staff increased by one or more health visitors, almost invariably these appointments were made at a lower salary.

In addition to the desire to pay a lower salary than that given to a woman sanitary inspector, London boroughs had a further reason for making use of the title of health visitor.

In London half the salary of all sanitary inspectors is paid out of the county rate and their duties are defined in Sections 107 and 108 of the Public Health London Act, 1891. A great deal of the work being done by the women sanitary inspectors could not be defined as coming within the scope of this order, and although some medical officers of health tabulated infant visits as visits to houses, &c., in order to qualify for the grant; still, it gradually became more difficult for them to do so, and in some cases the Local Government Board auditor refused to sanction the payment out of the county rate of half the salaries of those women engaged in health visiting.

First London Appointment.

In 1905, Kensington appointed a health visitor and paid the whole of her salary out of the local rate. Then the L.C.C. General Powers Act, 1908, Section 6, empowered the Metropolitan Borough Councils to appoint health visitors and the L.C.C. to contribute half

their salaries out of the county rate. From this legislation the results were not wholly good. The number of appointments of health visitors rapidly increased as the London councils made use of the grant, while county councils began to appoint staffs of county health visitors who were able to reach country and outlying districts; while later on voluntary organizations for infant welfare work, following the example of the St. Pancras School for Mothers, the first of its kind, began to increase until in the course of fourteen years there were nearly 2,000 of such enterprises, including municipal clinics and hospitals with infant welfare clinics. By 1919 there were between two and three thousand women employed as health visitors in England by municipalities and more than three hundred engaged by voluntary societies, in connection with infant welfare work.

Substitution for Sanitary Inspectors.

The unfortunate propensity of many councils to offer totally inadequate salaries was responsible for a temporary lowering of the status of the woman public health official. Besides this, councils who had employed women sanitary inspectors, when the appointments became vacant, re-appointed health visitors instead at a lower salary who were unable through lack of legal status to carry out the inspection of workshops, &c.; and other valuable pioneer work which had been done by women inspectors was in many instances abandoned, or referred to the men inspectors. In London the majority of London boroughs employed their women officials in the dual capacity of sanitary inspectors and health visitors. This method has great advantages and prevents much overlapping of duties.

The county councils in many instances appointed women officials in the dual capacity of school nurse and health visitor, and this method in sparsely populated places other than towns large enough to employ their own health officials has great advantages and has shown

itself to be eminently satisfactory where the salaries are adequate and highly qualified women employed.

In many rural areas, the district nurse often quite uneducated was engaged to take on the duty of health visitor. In 1919, there were over one thousand * district nurses employed in the dual capacity of health visitor and district nurse.

The pioneer women sanitary inspectors were, for the most part, well educated women actuated by a love for social service. In those days no qualifications were asked for other than the Sanitary Inspectors' Examination Board certificate in London and usually the Sanitary Institute certificate elsewhere. When infant visiting by women sanitary inspectors became general and supervision of midwives was often part of the duties of the chief health visitor or woman inspector the certificate of the Central Midwives Board or equivalent, was asked for as an additional qualification, and very soon many towns and boroughs required nursing training in addition.

Varieties of Qualifications of Present Health Visitors.

Thus we have in the profession at the present time the following varieties of worker.

(1) Some of the pioneer women inspectors who are now acting in the dual capacity of woman sanitary inspector and health visitor, and who have no technical qualifications other than the Sanitary Inspectors' Examination Board or Sanitary Institute certificates which were all the qualifications required when they took up the work.

(2) Many of (1) who have obtained the certificate of the C.M.B. at their own expense having received permission from their councils to take time off for the purpose.

(3) Those who entered in at a later period having the

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* Figures supplied by the L.G.B., February, 1919.

C.M.B. certificate, the sanitary inspector's or health visitor's certificate and usually a few months' training at a children's hospital or elsewhere.

(4) Fully trained nurses either with or without the C.M.B., and having also the health visitor's certificate.

(5) District nurses in some cases having only a few months' hospital training, and no other qualifications, except experience of district nursing.

(6) Health visitors who obtained posts some years ago without any technical qualifications whatever and continue to hold office.

As regards general education, the profession contains every variety from those who have University degrees and skill in lecturing, public speaking and writing, to those who, judging by their letters and applications for appointments, have not had the opportunity of learning to spell or write grammatically. The exact training required at the present time is given in detail in the following section ; but one curious fact may be noticed here and that is that as the qualifications required in advertisements for health visitors increased, so the salaries decreased, which on the surface appears very remarkable until we remember that it was the differentiation of the work and the giving over to health visitors of duties that could not be undertaken by men that brought about this reactionary change of status. One unfortunate result was that many women of experience and ability to do the work supremely well took the first opportunity of escaping from a profession that offered such poor prospects ; similarly many women admirably suited for the performance of a public health official's duties abstain from qualifying themselves for the profession for the same reason. At the present time just as there are great differences in education and training among acting members of the profession, still more are there extraordinary differences in salaries. In London alone, there are some metropolitan boroughs paying £350 initial salary to their health visitors of a year or two's experience, while others

are giving a maximum of little over £220 to highly trained women of many years' experience.

Prospects.

The greatest drawback to the profession has been this inequality of pay, and the absolute lack of guarantee to any health visitor who took up work in the past that the remuneration would be adequate has driven many valuable and experienced workers into work where, although they were better paid, a large part of their special experience was wasted. There are signs since the Civil Service treasury scale has been adopted by many councils, and the Whitley Commission instituted, and the Women Sanitary Inspectors' and Health Visitors' Association converted into a registered trade union, that some unification of salaries may be adopted throughout the profession. The chief obstacle to this much-to-be-desired reform is the apathy of many councils the majority of whose members are very far from enlightened.

It is not pleasant to be employed by a body of people whom it is impossible to respect, but it would be more endurable if the salary was definitely arranged by the Ministry of Health, since it is with the medical officer of health and not the council that the health visitor comes most into contact. Another great drawback to the profession is the necessity of finding a suitable appointment for life before the age of 35 or thereabouts. What frequently happens is that a health visitor obtains an appointment in a locality that she likes at an initial salary that compares favourably with that of other districts. She remains there some years getting thoroughly attached to the place and people and then finds that the council refuse to raise her salary, while health visitors in surrounding districts with, it may be, less qualifications and experience than herself are earning considerably more (at the present time this difference may amount to £120 to £130). The health visitor is practically debarred

from changing her district because she is over 35, and few new appointments are given to health visitors beyond this age.

Even supposing she has not reached this age and makes a change of district she has to sacrifice the difference between the inital and maximum salary and few health visitors can afford to do this. Quite the most interesting, wholly absorbing and inspiring of any work that exists is, under favourable conditions, that of the health visitor. It is almost her daily lot to be stopped in the street and thanked by mothers who acknowledge that they owe their children's lives to her. I noticed with amusement in a recent newspaper correspondence, when an acrimonious attack was made upon health visitors, that not one professional health visitor took part in it. The reason is obvious. They are all so busy trying to keep up with the demands made upon them by the mothers themselves that they have no need to justify themselves. The mothers do that for them!

There is a deeply seated crying need on the part of young mothers—yes, and sometimes old mothers too—to be instructed and encouraged in the rearing of their infants, and I deprecate the suggestion sometimes made that the health visitor is only a stop-gap!

It may be that in the future her work may become more purely educational than it is able to be at present; it may be unnecessary at some far distant date to do so much home visiting, and the health visitor may be able to concentrate more upon lectures at the schools for mothers; but we can no more do without her than we can dispense with our school teachers.

Hints to those about to become Health Visitors.

To those desiring to take up the profession at the present time the following hints may be useful :—

(1) *Age limits.*—Unless there is some very special reason such as strong interest amounting to a promise for some particular post, an overwhelming attraction for the work,

or the possession of sufficient private income to make her absolutely independent, the aspiring candidate is advised not to take up the work unless she has obtained all the qualifications before the age of 30 (see chapter I for qualifications). This or a younger age enables the qualified visitor to pick and choose, to take a place for experience, and leave it for another if not suitable. If the candidate is much over this age, there is always the risk of the door being closed before she has had time to get enough experience to qualify for the best posts.

For it is experience in public health work that is required for all the best appointments. The profession has suffered in prestige somewhat in the past from being supplied by "failures" in other professions, and although the qualifications now demanded have mitigated this, still one comes to such arduous work all the better for being fresh and not already disillusioned by misfortune in some other profession.

(2) *Health.*—Under good conditions, i.e., reasonable hours and holidays, sufficient salary and a medical officer of health who allows scope, the profession is a healthy one, but women who have any weakness such as a *delicate throat* are advised to avoid it—as talking in noisy places, being out in all weathers and visiting dirty people is bound to produce a septic throat occasionally.

Flat foot or other inhibition to walking is also a great handicap to a health visitor. Those with any other physical disability that would hinder the work, are advised to avoid the profession. On the other hand, I have known cases of women who were not well when living an indoor life who were greatly benefited in health by the exercise in the open air.

Some people who are excellent teachers and who find the nervous strain of teaching all day too great take kindly to the far briefer periods of strain varied by walks in the open air which is demanded from health visitors.

(3) *Character and Mental Equipment.*—As regards

mental qualities, what is required varies according to the nature of the duties. The best health visitor would combine the qualities of a doctor, a teacher, a student of domestic economy; she should possess the arts of a ready public speaker and a perfect hostess, in short she should be a perfect paragon, in which case she would probably find another better paid outlet for such talents!

The one essential is the capacity to influence and get on with people. I have known one or two health visitors who openly said that they did not like "the poor." Needless to say they were not successes in the profession.

Most health visitors are too fond of their work, if anything; they do not resist sufficiently the temptation to neglect proper rest at meal times and carry on after hours. Every young enthusiast in public health work starts with the same faults, and the one who learns the quickest to conserve her energy and control her zeal is the one who does the most lasting good.

A very short spell of overwork in a life that is invariably without sufficient rest for any large reserve of strength may lead to over fatigue and nervous debility.

She should remember that work done for any length of time in a fatigued condition ceases to be good work.

Professional Association.

Directly the health visitor is qualified she should apply to the Secretary of the Women Sanitary Inspectors' and Health Visitors' Association and become a member (see Appendix I).

There is no one more lonely than a health visitor in a strange town and the Association will form a link with the outer world as well as being invaluable in giving information on any difficult points.

Selection of Appointments.

If the health visitor possesses any power of choice, as she should do if well qualified, let her avoid accepting

appointments where the conditions (other than salary, hours and holidays which are more a question for the whole profession to take up) are known to be bad.

There are districts where health visitors are known never to stop long. One on record had eighteen changes for two places in twelve years.

A little inquiry would have saved many of these health visitors a false start.

Generally speaking, medical officers of health are pleasant to work with and loyal to their staff, but instances are known to the contrary and if the health visitor takes pains at once to get to know the other members of her profession she will have every opportunity of hearing which are the districts of good repute.

Apart from the personnel of an office, districts vary very much from other reasons. Thus a central London Borough taxes the health of the visitor more severely than a breezy outlying district, a small country town will be healthier than a large manufacturing town, &c.

At present, salaries bear no relation to the healthiness or otherwise of the place.

Ultimately if every health visitor made careful enquiries before applying for an appointment, there would have to be a levelling up of salaries, and a reduction of hours or increased holidays for the less desirable places and this would be a fair method of arranging matters.

Advantages of Dual Appointments.

The health visitor if she contemplates taking work in London, is specially advised to qualify as a sanitary inspector, as whether she takes a dual post or not she should know intimately the clauses in the public health acts and by-laws relating to the duties of the sanitary inspector and thus avoid giving trouble by reporting nuisances which are not remediable under these Acts.

There are signs of a return to the earlier plan of appointing women sanitary inspectors in addition to health visitors. Thus Bethnal Green, which originally

had a woman sanitary inspector and replaced her some ten years ago by a health visitor, has now advertised again for a woman sanitary inspector.

Those who have worked in the dual capacity of health visitor are aware of the very great advantages accruing therefrom. Many times have I been told about some ill-used infant by a neighbour in the same house who was able to call me in to look at the state of her room with a view to my having it cleansed by the landlord, and thus was able to avert suspicion as to the source of information.

The inspection of tenement houses is specially suitable for someone doing health visiting, as it enables one to make friends with a large number of people other than mothers of babies, as well as being a means of discovering many babies, who, owing to their parents having removed or other reasons might have been overlooked.

Also, variety of work is much less tiring, and however fond one may be of babies, one does more justice to them if one has other duties to perform as well.

Besides the good effects upon the health visitor of variety of work, it is a great advantage to the people to avoid reduplication of visits.

The Women's Co-operative Guild have put the point very forcibly in one of their pamphlets, as regards the overlapping of the present system, and county health visitors and school nurses find also the advantages of their dual position for the same reasons.

No doubt as well as the causes already mentioned, which led in many cases to the substitution of the health visitor for the sanitary inspector, it was the continual high infant mortality while the general death-rate was steadily falling, which caused so much attention to be directed to infant welfare to the partial neglect of other public health problems.

In many districts health visitors with hospital training only and with no public health outlook were appointed. It is interesting to note, that in the United States of

America, the same tendency was at work and that when public health nursing became specialized, it was soon found desirable to give post-graduate courses in public health to those nurses who desired to take up the work.*

Necessity for Keeping up Public Health Knowledge.

It is essential that a health visitor to do good work should have the public health point of view: and this has been recognized by the scheme of training suggested by the Board of Education.

In becoming an apostle of Preventive Medicine, the health visitor is up against the bad habits induced by superstition and artificial methods of living of a whole nation, and she needs to be well armed for the purpose. Thus, she must keep up with new methods by reading and attending lectures.

Monthly journals giving short reviews of new books on public health matters and articles by experts are invaluable particularly to health visitors working in isolated places.

Growth of Infant Welfare Movement.

Looking back sixteen years, the improvement in the habits of the working class people with regard to their treatment of infants is so remarkable, that it enables one to hope that this improvement may be maintained and extended to cover all the habits of life.

The health visitor has unique advantages in influencing public opinion. Let her drive into one obstinate mother's head, that medicine is not to be given indiscriminately to children, that insufficient breast milk can be supplemented without hurt to the baby, that quack medicines and patent foods are not to be taken on

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* See account of History of Movement in Public Health Nursing, by Mary Swale Gardner.

their own valuation, that bringing an infant into the world does not also provide one with a complete knowledge of how to rear it, and she has probably made an impression upon the whole circle of that woman's acquaintance.

While there are men like Dr. Eric Pritchard and Dr. Truby King to inspire and lead us, there is no chance of the work becoming dull. Even in a period of twelve years the change in public opinion towards child welfare matters is very marked. Then, the obstructive grandmother was a common feature, tube bottles were frequently found, hard binders and unsuitable infant clothes were far more usual. Now the grandmothers (certainly in the district in which I worked) are usually on the side of the angels, tube bottles are rarely seen, the standard of infant clothes and treatment generally has risen enormously. More than that, the first question usually asked by a new mother is "When can I bring baby to the Centre"?

The opening of dental clinics universally is only a matter of time, the suppression of quack medicines and deleterious and worthless patent foods, the extension of the Public Health Acts to the dirty habits of tenants as well as to structural defects, the further protection of the public from doctored food, the establishment of an increasing number of garden cities; all these things are within reach of the present generation and the health visitor has enormous opportunities of helping to bring about these changes.

It has been pointed out recently that if the railway companies' employees were to try and keep all the rules issued for their guidance, few trains would reach their destination during the day. So in the case of the health visitor, she must know and observe all the unwritten laws of etiquette and good manners, she must avoid all occasions of giving offence and yet if she were to follow this advice literally she would be afraid to leave the office and go visiting in other people's houses at all, or if there

speak to any purpose. Therefore, let no health visitor be disheartened by all the vetoes in this book. There are ways of getting round most things. To take a concrete example :—

If she finds a mother giving A's food to an infant and she has reason to believe that A's food is extremely bad for infants, she does not if she is wise say : "All infants fed on A's food get rickets you had better take dairy milk mixed in accordance with directions given at the welfare centre ; " this may get her into trouble with A's agent, but she says : "All patent foods are inferior to properly mixed dairy milk, your child will very likely be rickety," &c. Further, if the mother comes to the centre the doctor as a rule, has no objection whatever to give an unbiassed opinion on A's food, so the health visitor thus accomplishes the same end without the disagreeable possibility of a libel action.

The popular health visitor has her advice asked on so many points that she cannot be too careful of the form in which she gives the answer, but this need not prevent her, if she chooses, answering as her sympathies dictate.

Scope and Opportunities of the Profession.

To those women then, under thirty, who wish to take up the very finest and most satisfactory form of social work free from all political or sectarian bias, who would like to win the friendship and gratitude of many working class people and obtain an insight into the conditions of their lives, who are prepared to stand up for their rights as to adequate holidays, salary and hours of work ; the profession of health visiting can be recommended to fulfil all expectations.

Especially is it suitable for those women who are not compelled to earn their living.

Just as nursing, a far more arduous profession, has always appealed to a number of women, irrespective of their being required to work for their living, so health visiting makes a similar call upon the sympathies, and at

present the demand for trained competent women is greater than the supply.

Provided that a woman of means when taking up paid work of any kind is particularly careful to lose no opportunity of improving the conditions of that work, she will be a source of help and not a rival to those brave enough to take up health visiting (which of necessity must often bring them into contact with sordid conditions) without other means of support. As regards general prospects. Salaries just now are in a chaotic state, some advertisements still appearing that offer less than £200 initial salary; while others offer a commencing salary of £350 rising to £450.

However, an energetic woman well-qualified and endowed with a pleasing appearance can choose where she wishes to work and may ultimately expect to get a salary that does not compare unfavourably with an assistant secondary school teacher or a primary head teacher; but there is nothing further to be looked for than this within the profession which has caused a large number of the more capable members to take up other work. Within recent years, health visitors have obtained posts as inspectors under the Insurance Act, welfare supervisors, both Government and commercial, housing inspectors under the Ministry of Health, and nurse inspectors of infant welfare centres for the same department, various other odd appointments such as a secretaryship to a public man, an agent for a well known dried milk firm, &c., have attracted others from their public health appointments.

A certain number of health visitors are paid so badly that they are compelled to take other work to supplement their incomes, such as writing articles, lecturing and coaching students for examinations. One very capable health visitor returned to the teaching profession as offering better pay and another became a journalist. Many councils have superannuation schemes by which the health visitor is enabled to provide for her old age,

but the profession is too young for this system to be in operation. The whole matter is under discussion at the present time and it is probable that health visitors will all shortly be included in a Government superannuation scheme, made obligatory upon all councils that employ them

CHAPTER I.

TRAINING OF HEALTH VISITORS.

When health visitors were first appointed, some were qualified as sanitary inspectors, but others possessed no special experience or training of any kind. It was affirmed that preparation for the work was unnecessary, and if a woman could make her statements sound like irrefutable facts, no scientific truth was demanded in her teaching. It is fully acknowledged that the power of gaining confidence is essential, but just as a "quack" with a good bedside manner is not qualified as medical adviser, so a health visitor without training is dangerous to the public.

Qualifications Prescribed by Law.

The *London County Council (General Powers) Act*, 1908, empowered sanitary authorities to appoint women to be known as health visitors, and the *Health Visitors (London) Order*, 1909, was the first attempt to prescribe their qualifications and duties. It was stipulated that no appointment should be made otherwise than in accordance with these regulations. The alternative qualifications prescribed by the Local Government Board in the Order were as follows :—

(*a*) A medical degree, or

(*b*) The full training of a nurse, or

(*c*) The certificate of the Central Midwives Board, or

(*d*) Some training in nursing and the health visitor's certificate of a society approved by the Board, or

(*e*) The previous discharge of duties of a similar character in the service of a local authority.

These Regulations applied to London only, so that outside London local authorities were still free to appoint women with no training of any kind.

The qualifications usually demanded in advertisements for appointments are one or more of the following :—

(i) The full training of a nurse.

(ii) The certificate of the Central Midwives Board.

(iii) The certificate of a sanitary inspector or health visitor. In most cases two of these three qualifications are required.

The age for commencing training has been necessarily late. Probationers are not usually accepted in hospitals for general training until about 25 years of age, and women cannot be qualified as midwives or sanitary inspectors until attaining the age of 21. Advertisements of vacancies offer no incentive to early training, since health visitors are usually required to be not younger than 25 years of age at the time of their appointment. Thus many women have undergone training for other professions and followed diverse occupations before entering the Public Health Service.

One of the most important documents concerning the profession of health visiting, and marking a great advance on every hand is the *Ministry of Health Circular to Local Authorities* (*M. and C. W.*, 10), July 14, 1919. This circular embodies a determined effort to raise the standard of qualifications for newly appointed health visitors throughout the country, and introduces *Regulations* authorizing the establishment of one statutory qualification. It is pointed out that the Local Government Board in the past constantly recommended that health visitors outside London should possess one or more of the qualifications prescribed by the London Order, with the addition of the certificate of a sanitary inspector; but these recommendations are now to be forcibly applied. It is prescribed that "Local authorities making new appointments of health visitors from the present time until women qualified under the new

Regulations are available, should always endeavour to secure more than one of the qualifications already prescribed for London . . . and the Ministry will not, as a rule, be prepared, after a date of which due notice will be given, to pay grants in respect of the salary of any newly appointed health visitor who has only the qualification of a midwife or of a sanitary inspector, unless she has previously rendered satisfactory service as a health visitor in another district."

Board of Education Scheme.

The new Regulations cited as "*The Board of Education (Health Visitors Training) Regulations*, 1919," drawn up in consultation with the Ministry of Health, provide for a special course of professional training, in which it is anticipated that students will be able to concentrate on the subjects essential to health visiting and eliminate all studies not directly relevant. For example, it is cited "that the three years' training necessary for a fully qualified hospital nurse or the training for the certificate of the Central Midwives Board is of value to a health visitor; but these courses do not cover many of the functions which a health visitor may be expected to perform."

The new course of training will not be compulsory for health visitors already holding appointments, but where women are desirous to qualify under the new Regulations, it is hoped that local authorities will grant facilities for the purpose.

When the time has elapsed necessary to establish the requisite courses of study, and after the completion of the training of a sufficient supply of health visitors, it is anticipated that grants will be made to local authorities for newly-appointed health visitors, only in respect of those new *entrants* who are qualified according to the Regulations.

Outline of Regulations.

(1) Courses of study to be recognized by the Board of Education must be conducted by, or in close association with, a university institution.

(2) The scheme of training must provide for both theoretical instruction and practical work in about equal proportions.

(*a*) *Theoretical instruction* should include

(i) Elementary physiology, and the structure of the body.

(ii) Methods of artisan cookery and household management.

(iii) Hygiene.

(iv) Infectious and communicable diseases.

(v) Maternity, infant and child welfare.

(vi) Elementary economics and social problems.

(*b*) *Practical work* may include

(i) Visits of inspection to institutions.

(ii) Work in an infant welfare centre.

(iii) „ „ a school treatment clinic.

(iv) „ „ a maternity hospital.

(v) „ „ a day nursery.

(vi) „ „ a maternity centre.

(vii) „ „ a tuberculosis dispensary.

(viii) „ „ connection with elementary economics and social problems.

(3) Candidates to be of good general education—preferably educated at a secondary school.

(4) Age not younger than 18 years when beginning training.

(5) The course to consist of two years' preparation, except for

(*a*) University graduates.

(*b*) Fully trained nurses.

(*c*) Health visitors who have held a whole-time appointment for not less than three years.

In these cases (*a*), (*b*), (*c*), the shortened course of one year's duration may be substituted.

For complete circular, see Appendix II *b*.

For Training Institutions recognized by the Board of Education, see Appendix II *a*.

For Institutions not recognized under the new Regulations, see Appendix II *a*.

It will be seen that these regulations are the result of careful investigation and mature judgment. For several years health visitors have been endeavouring to obtain one statutory qualification for new entrants into the profession, and, as an outcome of their intimate knowledge of the work, they have formulated a scheme of training. It is a matter for congratulation that the Board of Education Regulations are so closely in accordance with the Health Visitors' Training Scheme, since the latter represents the views of the most experienced and highly qualified members of the profession.

No longer should the training of health visitors be haphazard and erratic, but any institution undertaking approved courses of study must make provision for the whole training—both theoretical and practical. This is a great advance on former arrangements where training bodies advertised theoretical courses and examinations for health visitors, and candidates undertook such training in the belief that it would be an adequate qualification for appointment. It has come to many as a bitter disappointment that, having spent time and money on theoretical courses, they must either find considerably more money for additional training (and sustenance during practical work) or give up the idea of Public Health Service and waste the expenditure already incurred. Students failing to seek advice from experienced public health officers and guided solely by the syllabus of training institutions were not in a position to understand the provisions of the Health Visitors (London) Order, or even to know the names of periodicals advertising appointments and stating the qualifications required. It is the greatest advantage to candidates, and to the profession as a whole, that students trained at approved

institutions will not in future enter the profession blindfolded.

Inevitably there are still some uncertainties with regard to appointments. As stated in the Regulations, local authorities may expect their health visitors to possess additional qualifications, and intending students would be well advised to watch the advertisements in appropriate periodicals (see chapter on application for appointments). If a candidate decides to undergo full training as a nurse, three years must be spent in a hospital *recognized as a training school for nurses*. She must not be younger than 21 years of age. She will receive board, lodging, uniform, laundry and a small salary, except in the case of one institution where probationers live at home and are paid two guineas weekly. The shortened course for health visitors (one year's duration) is applicable to fully trained nurses, and a suggestion has been made that hospitals, which are training schools for nurses, should also have training courses for health visitors. Here, it is surmised, that students would still receive board, lodging and salary as when probationers. The great drawback to this innovation is, that students would have to spend four years in one institution with limited change of outlook, in preparation for a life work which demands initiative and versatility in the highest degree. The Regulations wisely prescribe that the courses shall be in association with a university institution—to ensure the requisite standard of work and because it "affords exceptional opportunities for free intercourse with other classes of students, a matter of perhaps special importance to future health visitors."

Health visitors wishing to become certified midwives must be trained at institutions recognized by the Central Midwives Board. The length of training is six months with a minimum of four months for fully trained nurses. The fees vary from about twenty-eight guineas to £47 for six months and from eighteen guineas to £30 for four. The student must calculate for additional expenditure

on uniform, laundry, bag and equipment, books, fares on district, examination fees, &c. Training institutions where cases are attended both in hospital and on district, are the most suitable for health visitors. The hospital gives opportunities for studying abnormal cases (and ante-natal complications are particularly important to health visitors) while midwifery on district gives deeper insight into the homes of the people than any other section of training. If a health visitor is also a midwife, she possesses a qualification that is greatly respected by both mothers and fathers on the district, and she is in a much better position to investigate cases of still-births than the health visitor with only two months' maternity training.

It is essential that health visitors should work in harmony with practising midwives, and co-ordination is easily effected when public health officers and practising midwives can talk together at midwives' meetings.

Sanitary Inspector's Certificate.

During her training as a health visitor, the candidate will require to study a considerable proportion of the course specified for sanitary inspectors. The question then arises whether it is worth while to take that examination. The Regulations suggest that it will usually be found desirable for health visitors to cover the whole course for sanitary inspectors. Although the proportion of vacancies for women sanitary inspectors is not great compared with advertisements for health visitors, yet these appointments are occasionally advertised. In London the certificate of the Sanitary Inspectors' Examination Board is required and in the Provinces either the above, or the certificate of the Royal Sanitary Institute.

The student will doubtless realize that to possess additional qualifications bearing on her work, and involving very little extra outlay, is a great advantage. Should she for any reason leave her profession, and

some years later find herself in need of employment, she might be considered too old for appointment by a local authority (see chapter on appointments). But if she had alternative qualifications (e.g., midwifery) she could take up other work.

Beside the uncertainty concerning additional qualifications possibly required by local authorities, there has been some doubt expressed with regard to the appointment of health visitors qualified at the age of 20. It will have been noticed that the Regulations anticipate this difficulty and further training is suggested as one solution. An alternative is the employment of these girls in posts of limited responsibility at infant welfare centres; but it is yet to be seen whether local authorities will pay a living wage to health visitors doing the work normally carried out by voluntary helpers. Maternity and child welfare clerks are being appointed in increasing numbers in many boroughs, and newly-qualified health visitors will be eminently suited for these appointments; in some of these appointments typewriting and shorthand are not required.

It will be seen that many of the institutions not recognized under the new Regulations offer only theoretical training, and although intending students are advised to enter for a course at a college approved by the Board of Education, it may be helpful to add a note about practical work under the old methods.

It is desirable that health visitors should have experience of nursing children, and though a three years' course of general training, including much work in adult surgical wards is not essential, it *is* needful that health visitors should have cared for both healthy and ailing children. Experience at a "nursery college" is excellent for normal babies, and work in a children's hospital (or ward) is required for sick nursing. Students will have to make their own arrangements for this practical experience unless entering an approved institution.

Pupilage and Unpaid Experience.

Before the demand for health visitors was so great, a candidate for an appointment had little chance of a post unless she had previously carried out the duties of health visitor. Thus many women, after completing their training, applied for voluntary work in the department of a medical officer of health. It was not invariably easy to arrange for this experience. Many councils had passed a resolution to the effect that pupil health visitors were not to be accepted. This was before municipal maternity and child welfare centres came into being, and when visiting occupied most of the health visitor's time. The regulation was made with a view to safeguarding the mothers from invasions of health visitors *en masse*. In other boroughs pupils were allowed to visit first with experienced health visitors, then alone, and under other authorities pupils were sent out unaccompanied from the beginning. Thus unbiassed by example, they were left free to visit the mothers in the way which came most naturally to themselves. Yet the advice of the experienced health visitor was daily obtainable when visiting reports were under review, and students received practical hints included in no advertised scheme of training. The art of eliciting information in informal conversation, the most tactful way of conducting death inquiries, the methods of avoiding friction with private practitioners, and the whole ethics of health visiting were carefully explained. Above all, it was impressed upon the pupil that her work was educational and preventive. She was not an amateur doctor, but a teacher, and whilst having confidence in the usefulness of the advice she gave, she must still be prepared to learn.

Voluntary workers paid their own travelling expenses, and usually worked for three or more months. After this time a testimonial was granted from the Medical Officer of Health, and this proved of great value to the candidate when applying for appointments.

Under the new Regulations, students will spend a

considerable proportion of time attending child welfare centres, and if they are working under municipal health visitors, and show eagerness to learn the difficulties of the profession, they will have invaluable opportunities of benefiting by the experience of the officials.

Experience in health and social work can be obtained in the department of a lady almoner at a hospital, or in connection with philanthropic organizations; but, useful as this experience will be, it cannot—as preparation for public health service—take the place of pupilage in a municipal health department. The standpoint of different social agencies must necessarily vary, and although it will be of value to the student to know the methods and the help to be expected from each organization, she must understand that the health visitor's duty is a thing apart. People hoping to benefit by free hospital treatment or charitable help (such as might be obtained from the Charity Organisation Society) will be prepared to submit to didactic methods and detailed investigations which would not be tolerated for a moment from a health visitor calling at their homes. The student will remember that, in her own work, as demonstrated at the welfare centres, her aim is to meet the mothers as a friend on the common ground of womanhood, and, understanding their difficulties to help them to make the best of their circumstances.

General Education.

Very important for the future of the profession is the subject of general education. No fixed standard has been demanded in the past, and it is deplorable to find that there exist health visitors who cannot write accurately the simplest English. It has been noted by experienced workers when coaching students for examinations that some of the intending health visitors compared unfavourably as regards education with many mothers attending centres. In every class for mothers there are women of such bright intelligence and good

education that it is essential for the health visitor to be an able lecturer. She must be capable of attracting the clever mothers as well as influencing the slower women and she must be able to encourage questions and hold her own in argument.

It is seen in the Regulations that the student's previous education should be such that she is likely to profit from the course. No prescribed examination is indicated. Thus the education of a student must be judged, and her admission determined by the Principal of the College. It will be well if the standard insisted upon is not lower than that of the Senior Oxford and Cambridge Local Examinations.

CHAPTER II.

DUTIES.

Statutory Duties.

The statutory duties of a health visitor were first set forth by the London County Council General Powers Act, 1908, section 6, as follows :—

(1) "Any sanitary authority may on or at any time after the first day of January, 1909, appoint suitable women (to be known as health visitors) for the purpose of giving to persons advice as to the proper nurture, care and management of young children and the promotion of cleanliness and discharging such other duties (if any) as may be assigned to them in accordance with the provisions of this section.

(2) "The Local Government Board may make regulations prescribing the qualification, mode of appointment, duties, salary and tenure of office of health visitors appointed under this section and no appointment of a health visitor shall be made otherwise than in accordance with such regulations." Although the Notification of Births Acts, 1907, had been passed prior to this, making it obligatory in those districts which adopted the Act—on parents or other persons in attendance upon a mother at child-birth to notify the birth within thirty-six hours to the Medical Officer of Health ; there was no provision in this Act for making any use of the information thus obtained.

Health Visitors (London) Order, 1909.

In 1909 the Health Visitors (London) Order, 1909, came into operation and this following on subsection (2) of section 6 of the L.C.C. General Powers Act as above

sets out a list of qualifications for health visitors, conditions of their appointment and duties (see Appendix III for full text). These qualifications are so varied as to allow the appointment of almost any woman wishing to work as a health visitor, but the enumerated alternative qualifications gave some guidance to local authorities as to what was required and there were very few advertisements for appointments that did not require more than the minimum qualifications demanded by the Act.

Further, it enacted that no health visitor was to be appointed without the sanction of the Local Government Board which clause has enabled the Women Sanitary Inspectors' and Health Visitors' Association to interpose successfully by appealing to the L.G.B. to block the sanction of various appointments where the salary offered was below a living wage.

The duties laid down compel the keeping of records and the carrying out of any duties connected with the administration of any act with respect to matters relating to public health, the housing of the working classes and the notification of births, provided that they are not the duties of a sanitary inspector.

Presumably this clause is meant to apply chiefly to the personal habits of the tenants since it is difficult to follow exactly what these duties could be under the "Housing of the Working Classes" Act, seeing that the health visitor is not usually empowered to serve notices for nuisances and has no legal right of entry to any premises.

The Housing and Town Planning Act, 1909, section 36, however, states "*any person authorized in writing* stating the particular purpose or purposes for which the entry is authorized, by the local authority or the L.G.B., may at all reasonable times . . . . enter any house premises or buildings . . . for the purpose of survey and examination when it appears to the authority or Board that survey or examination is necessary in order to determine whether any powers under the Housing Act should be exercised . . . " One such authoriza-

tion in writing has been issued by a Metropolitan Borough to their health visitors in accordance with sections 6, 12 and 14 of the L.C.C. General Powers Act ; and is worded as follows :—

"The Council of the Metropolitan Borough of —— in the county of London, being the sanitary authority for the said Borough, in pursuance of the power conferred upon them in that behalf by the L.C.C. General Powers Act, 1908, have resolved and ordered that you, the above-named, being a health visitor of the said Borough, be and you are hereby authorized on and after the date hereof, whilst holding such office as aforesaid, to enter at all reasonable times any house, building, or premises in the district of the said sanitary authority, and which the said sanitary authority has by virture of the said Act the right to enter and this is and shall be deemed to be the written document properly authenticated on the part of the said sanitary authority showing your right to enter as aforesaid."

Outside London, to each local authority there is only one sanitary inspector authorized to serve notices, who is very often the assistant medical officer of health so that all other sanitary inspectors employed by the local authority are in the same position as health visitors in so far as they have no power to sign any notice they may wish to serve.

Under matters relating to public health could be included visits to measles, whooping cough and phthisis cases and possibly visits to verminous school children, though notices for cleansing the premises would have to be referred to the sanitary inspector. (For full details of the Health Visitors (London) Order, 1909, see Appendix III.)

Maternity and Child Welfare Act.

In 1918 the Maternity and Child Welfare Act was passed, following on which the Local Government Board issued a circular on August 9, 1918, giving further

suggestions with regard to the appointment of health visitors. Two paragraphs of which I quote in full: Paragraph 12—"As a result of their further experience the Board consider that the standard of 500 births to each health visitor, which they have previously suggested, should be modified. The functions of a health visitor should comprise the visiting and supervision of all children under school age in the district needing this attention; the visiting of expectant mothers who have attended at an ante-natal centre, or for whom visits are desirable; inquiry into still-births and the deaths of young children; and attendance at the centre to which women and children, including those whom she has visited in their homes, come for medical and hygienic advice. Where these duties are fully performed it appears to the Board that a district with about 400 births a year will be as much as one health visitor can undertake, unless the district is very compact, or is of such a class that many infants do not need visiting. The health visitor's district should, where practicable, be so arranged that it is served by one centre."

Paragraph 13. Qualifications of health visitors: "It is not practicable at the present time to prescribe a special course of training or a standard examination for health visitors generally. The qualifications prescribed by the Board's order of 1909 with regard to London are:—

"(*a*) A medical degree, or (*b*) The full training of a nurse, or (*c*) The certificate of the Central Midwives Board, or (*d*) Some training in nursing and the health visitor's certificate of a society approved by the Board, or (*e*) The previous discharge of duties of a similar character in the service of a local authority."

The certificate of a sanitary inspector is also valuable. In the absence of one or more of these qualifications the Board are not prepared to pay a grant in respect of a health visitor's salary unless they have adequate evidence before them that she is qualified for this work." (For full text, see Appendix IV.)

Further suggestions are made with regard to district nurses acting as health visitors, county nursing and County Council superintendent health visitors and voluntary workers (see Appendix II).

Municipal Duties.

Duties that are actually being carried out by health visitors at the present time, in addition to work done at welfare centres, are :—

(1) Visiting of infants.

(2) Visiting expectant mothers.

(3) Visits in connection with infants' deaths.

(4) Visits after still-births.

(5) Work in connection with milk depots. This is very exacting work as it entails constant vigilance both to see that the milk is properly mixed and delivered in accordance with orders (it is particularly liable to go wrong at holiday times), and to see that the mothers fetch it regularly and instantly notify the fact if the child is not thriving. It is only by the persistent visiting of all new cases, all children who are not thriving, all mothers inclined to have vagaries, and all the cases during very hot weather, that this work can be carried out satisfactorily.

(6) Lecturing at mothers' meetings, schools, &c. This is most valuable work, and the health visitor will gain much by co-operation with the school teachers. They can often tell her useful facts about the families she is visiting.

(7) Organization of voluntary health workers in the district and arrangement of their work. This entails a great deal of office work, but since the great increase in the number of appointments of health visitors, this work is likely to decrease except in connection with infant welfare centres.

(8) Visiting cases of measles, whooping cough, scabies, &c. In the provinces additional duties are carried out by health visitors :—

(9) Work in relation to the administration of the Midwives Act.

(10) Inspection of shops under Shop Hours Act, 1892-94; Seats for Shop Assistants Act, 1899.

(11) Work in connection with medical inspection of school children. For details of this work see article on County Health Visiting.

(12) Inspection of Nurse Children under the Children Act. This work is done in London by inspectors employed by the L.C.C. for the purpose. Outside London it often forms part of the duty of the health visitor. As by the Children Act, 1907, all persons taking in one or more children for night as well as day for payment are obliged to be registered, this work is very important. A considerable number of cases were found to be unregistered in London before the war, and there are probably many still, but not as a rule from any malignant motive, merely from an ingrained dislike for writing letters and fear of interference.

The health visitor or inspector of boarded-out children should always endeavour to get the infant taken regularly to a welfare centre, and should ask to see the weight card at each visit. Otherwise she should weigh the infant herself with a portable weighing machine and insist upon medical advice if the child does not thrive or has any ailment.

(13) Crêches. Whether inspection of crêches comes under the work of health visitors or not varies with the district, but at least every health visitor should get into touch with the local nurseries and crêches, as she will often find the matron a valuable help, and she will be able herself to assist the matron by telling her about lapsed cases, &c.

While the health visitor should do everything in her power to render crêches unnecessary by persuading mothers to stay at home with their children, there are occasions when they are a valuable help as a temporary expedient in the case of a mother's illness, or disability

to care for her child. The best form of crêche is undoubtedly the emergency crêche held in connection with a school for mothers and taking in only a small number of children. The health visitor will often have to combat an opinion born of ignorance of the real facts that crêches are desirable, and if she keeps careful statistics as the writer did for many years, she will find that the mortality from infectious diseases and pneumonia, and bronchitis from children who have regularly attended a crêche from a month old is very high.

(14) Visiting Verminous Children. This usually entails an inspection of rooms and bedding, and one or more revisits to see that the mother carries out and maintains the cleansing. Old premises where the walls are permeated with bugs, are particularly tiresome to deal with, as disinfection by fumigation of the rooms by sulphur may be frequently carried out and yet the bugs return. However a great deal can be done for cases of body vermin, lice and fleas, by impressing the importance of cleanliness on the mother, and pointing out the certainty of the condition recurring and leading to difficulties with the school authorities if steps are not taken to prevent it. The great difficulty of this work is the large residuum of unteachable people for whom the present laws relating to vermin are quite inadequate.

Thus the L.C.C. General Powers Act, 1907, provides for compulsory cleansing of the school children, and the compulsory cleansing of verminous premises, but leaves out the parents and children above and below school age, who if not also attended to at the same time immediately reinfect the home and render fruitless the efforts of the school nurse and the sanitary authority. However this work is generally speaking, very gratifying to the health visitor in that she is often enabled to arrange for proper care of neglected children who so frequently become verminous. For instance, the writer remembers one miserable little boy sitting down to a bread and scrape dinner by himself in a dirty room, his mother

being out at work. I visited again when the mother was in and found that the fact that her child had been reported verminous, had so disgusted her that she decided forthwith to give up the work, which in her case was not a necessity, and the boy got better dinners and was never again reported as verminous. It must be noted that as in the case of mothers of children taken to crêches, besides the women who are compelled to go to work for various reasons, there are a large number who go because they dislike home life and the care of children, and during the winter time it is exceedingly difficult for a woman who works all day to see to the cleaning of her house and children, and hence the largest number of cases of verminous children are always found in families where the mothers go to work.

RELATIONS WITH MEDICAL OFFICER OF HEALTH.

The health visitor appointed by sanitary authorities is an officer of the Public Health Department, and acts under the Medical Officer of Health. Her statutory duties are laid down by the Ministry of Health; subject to these the Council of the Sanitary Authority may lay down specific duties for their district, but in many places it is simply left to the Medical Officer of Health to allot the work to each member of his staff. He is the commanding officer and his orders must be carried out so long as they are lawful and reasonable. The health visitor who considers herself aggrieved can always appeal to the Council or the Committee of the Council dealing with the officials of the department; she will do this through the Medical Officer of Health. But such a course will seldom if ever be necessary. Her chief will usually be anxious to see that all his staff are treated with justice and consideration, and to give patient hearing to any complaint made to him. To appeal over his head to the committee would argue gross unsuitability of character in one of the two officials concerned, and the

health visitor will be wise to regard herself as the defaulter, and to patiently bear the supposed grievance.

Every Medical Officer of Health has his own way of carrying out his work. Some prefer to leave their responsible and expert subordinates pretty much to themselves; others with highly developed conscientiousness like to supervise every step and to know every detail of their work. It will be, of course, for the health visitor to accommodate herself to her chief. Usually he will be satisfied to let her carry out her work in her own way, but will want a report at weekly or longer intervals, both for his own information and to present to his committee. All reports for the committee go through the Medical Officer of Health and should be addressed to him.

It is a good plan for him to see the health visitor say once a week, and go through her journal with her. In this journal she will note her visits, the conditions found and the action taken. The interview will enable the visitor to consult the medical officer in all questions as to which she seeks advice. It will also give an opportunity for her to make any suggestions for new developments of the work, or for in any way improving its character.

Visiting for infant welfare work is of such a nature as not to lend itself easily to categorical and systematic reports like sanitary inspection and infectious disease visiting; and health visitors have to steer between reporting nothing except that the visit was paid and going to the opposite extreme of making a short story of each case. The Medical Officer of Health will be glad of enlightenment as to just what the visitor does when she visits a notified birth or a consultation case, and the visitor will rightly wish to interest him in her work, but she should remember that she must not waste time in writing out immaterial details, nor waste her chief's time in submitting them to him. She should note briefly all cases improperly fed, e.g., "fed irregularly on condensed milk," and report any specific advice given, e.g., "recommended

four-hourly feeds." She should mention such details as "dirty home," "mother delicate," but should avoid a full description of the baby and the history of the mother. At the second visit the most important thing is to note to what extent her advice has been carried out, e.g., "baby now fed regularly on dried milk as directed," "home cleaner and ventilation maintained." The point to aim at is to give essential information in few words and avoid unnecessary detail, and to remember that the Medical Officer of Health—especially if he is not the medical officer of the infant consultation—is not specially interested in the infants and mothers referred to, but does want to know that sound advice is being given, and that the visits are productive of good.

Many health officers are well up and keenly interested in infant welfare, and will be in a position to give valuable counsel and practical suggestions. Some on the other hand are the reverse, and with them the health visitor may reasonably aim at instructing her chief and attempting to develop his interest. But let her be careful how she does it. Her monthly report on her proceedings affords a good opportunity. Women often seem freer from official restraint in their modes of expression than men who have long worn bureaucratic harness. Such freedom is a distinct advantage. A health visitor can do a good deal of pioneer work through her reports.

A great many large boroughs now have a woman assistant Medical Officer of Health, who is specially charged with the supervision of infant welfare. When this is the case the health visitors will—as regards infant welfare—work under her, and will probably find it of great advantage to have a medical expert to refer to who is primarily interested in their work.

CHAPTER III.

MUNICIPAL WORK.

A HEALTH visitor may obtain a post either directly under a municipal authority or indirectly by working for a voluntary society which obtains a grant from a local authority towards her services.

Health visitors are strongly advised to avoid taking these indirectly municipal posts unless it can be guaranteed that the conditions are in no way inferior in respect to salaries. increments, holidays, hours, and superannuation benefits to those obtaining in the best municipal posts. Local authorities are inclined to contract out in order to avoid responsibility, and save themselves trouble, and health visitors must be on the look out for this form of exploitation.

The advantages of a municipal post are :—

(1) Security of tenure. (Municipal health visitors are only discharged for very serious offences.)

(2) Payment of full salary during sick leave.

(3) Fixed hours and holidays.

(4) Participation in any bonus or superannuation scheme adopted by the municipality.

(5) Avoidance of friction by working directly under the medical officer of health instead of for a voluntary committee, the members of which may or may not be sympathetic towards their employees.

HOURS OF WORK.

The usual hours of work for a municipal post are 9 a.m. to 5 p.m. Saturdays 9 a.m. to 1 p.m.

At some places in the provinces the work may continue till 6 p.m., but this is usually partly compensated for by a longer dinner interval.

Since, however, the establishment of infant welfare centres there has in some districts been a great tendency to work health visitors overtime, and when it comes to work hours protracted to after 6 p.m. on three or more days in the week, the health visitor should obtain time off on Saturday mornings, or otherwise to compensate for the extra fatigue involved by these long hours.

Holidays.

Holidays vary very much. The provinces are usually better off than London in this respect.

Most county health visitors get four weeks' annual leave with a little extra time at Bank holidays.

There are still some districts where only two weeks' holidays are given and no extra time at Bank holidays. This is, of course, totally insufficient, and health visitors who work for any length of time under such conditions are occasionally obliged to obtain medical certificates for further leave of absence, or their health would be permanently impaired.

In some districts the medical officers of health are reasonable on this point and permit extra time off, leaving early on Saturdays, coming late after week-ends on Mondays, &c., so that the actual conditions are much better than appears on paper.

The holidays, for the most part, are totally inadequate throughout this branch of municipal work. Superannuation benefits, as has been already stated, have hardly come into use yet, but health visitors may reasonably expect not to receive less than has been given to men sanitary inspectors.

Pensions.

The City of London has formed a good precedent by awarding a pension equal in amount to one-half of her maximum salary to Miss Safford, its first woman sanitary inspector, when she retired in 1919 from ill-health after sixteen years in the City.

A further advantage of a municipal post is that one is easily able to obtain what one wants in the way of equipment. Most voluntary enterprises are menaced by the lack of funds, and this does not fail to react on the worker.

Salaries.

Anything from £150 or less to £300 may be offered as an initial salary.

Voluntary Societies.

Many posts under voluntary societies are open to women with a health visitor's training, particularly in connection with infant welfare work.

The superintendents and assistants for an infant welfare centre are often engaged independently of the medical officer of health and his staff, though they should always work in co-operation with the municipal staff. The chief advantage of these appointments over municipal ones is that they are more elastic.

Thus part-time posts are frequently obtainable, thus enabling the health visitor to do other work or to devote some time to her own domestic affairs.

For this reason quite a number of ex-health visitors have done or are doing the work at the present time.

Then the work for a voluntary society is less routine-like in some instances. The superintendent is not tied down to visits in one area only; she may devote time to any problem that presents itself, or suggest any new ventures directly to the committee of the voluntary society, which is able to give her permission at once without the prolonged consideration necessitated by the municipal committee's responsibility to the ratepayers.

On the other hand the vagaries of voluntary committees are many, and it is generally accepted that they are more difficult to work with than a public health authority. Certainly the average time that superintendents of a voluntary centre stay in one post compares very unfavourably with that of the municipal worker.

It is also well known, alas! that quarrels are rife between the helpers at voluntary society centres; which

is hardly astonishing when we remember that they are dependent upon subscriptions and cannot afford to offend subscribers who naturally think they should have a say in the management.

Voluntary Work.

Voluntary work of necessity comprises all kinds of workers from the most devoted, unselfish and capable people to the incompetent, fussy and ill-mannered ones.

The perpetual problem for the official is: How to utilize the really valuable voluntary help that exists without being swamped by the "helper" who only hinders.

The Ministry of Health in its "Memorandum in regard to Maternity and Infant Welfare Centres," November, 1919, Section 2, deals with this question.

If a health visitor can obtain a post as superintendent with a really nice committee she may have a happy time and enjoy the work very much; there are instances of this, and if such a post offers itself in the locality where the health visitor wishes to work she may find the experience helpful, but unless she is only meditating temporary and not life long work she is advised to seek for municipal work.

Philanthropic and Commercial Appointments.

Hospitals often now employ a whole-time nurse to act as superintendent and visitor for their baby clinics and fully qualified nurses who have taken up health visiting often find this congenial work.

(1) *Agents.*—Certain infant food firms of good repute employ agents or travellers and the work is usually better paid than health visiting and may be very useful.

The same disadvantages apply to it as to working for a voluntary society, e.g., no superannuation rights or security of tenure; but to those who like commercial life it offers some attractions in that the agent usually attends all congresses and exhibitions, and has the opportunity of seeing a great deal of what is being done in public health work.

(2) *Welfare Supervisors.*—A number of factories now employ welfare supervisors and health visitors have taken up this work and enjoyed it.

Just as in infant food agencies, the pay is better but the work may be harder than that of health visiting and the same drawback obtains of loss of security of tenure and rights to superannuation benefits.

Government Appointments.

Up to the present time most of the health visitors who have obtained these appointments have also been acting sanitary inspectors, but this does not apply to the recently made appointments of nurse inspectors of infant welfare centres to the Ministry of Health at initial salaries of £250, rising to £500.

Quite a number of women sanitary inspectors some of whom were health visitors have obtained Insurance Act inspectorships, factory inspectorships, labour exchange appointments, and more recently temporary sub-inspectorships of Housing to the Ministry of Health.

The rates of pay, holidays and general conditions were better than those of the average health visitors, but it is interesting to note how very many of these ex-inspectors and health visitors are of the opinion that the work of health visiting is far more responsible and more valuable to the community than the better paid work of a Government official.

Certainly the conditions of work are much pleasanter under most local authorities than under Government, being less "red tapey" and irksome, and the health visitor has far more real responsibility and consequent appreciation from the people she works among than is possible in a Government appointment. Perhaps, some day, this may be realized by the Ministry of Health and the salaries and holidays of the health visitors brought up to the standard of the Civil Service, in which case I do not think many successful health visitors would change their work, but at present they are obliged to consider salaries before sentiment.

APPLICATIONS FOR APPOINTMENTS.

Appointments by local authorities, when vacancies occur, are advertised in local, daily and professional journals, and either daily or weekly papers. The nursing journals and those which appeal to local government officials are the ones most commonly chosen. Applicants should realize that as their applications have to be considered by one or two committees which only meet at intervals of perhaps one month, considerable time must elapse between sending in their applications and the appointment being made.

The following description of the *modus operandi* usually followed may assist those who wish to obtain a municipal post.

The applications are received, and classified, by a clerk, a full list being made setting out the chief items: e.g., name, age, address, married or unmarried, training, examinations passed, previous occupation and appointments, present appointment, names of persons giving testimonials. This list is carefully scrutinized by the Medical Officer of Health, Town Clerk, perhaps, and other officials interested. The responsible official, usually the Medical Officer of Health, forms his opinion as to the respective merits of the candidates and numbers them accordingly. The Public Health or other responsible committee at their next meeting discuss the merits of the candidates, each member being provided with a list, and guided more or less by the opinion of the Medical Officer of Health or other official, vote for the exclusion of the most unfit candidates, one by one or in block, so reducing the list to twelve or a less number of candidates whom it is decided to interview. Those selected are invited to attend the next meeting of the Public Health or Establishment Committee their expenses being paid. They should bring with them their original testimonials. They are then interviewed one by one, a few questions asked and their merits again discussed. The committee may be authorized by the

council to make the appointment, in which case, by what is called the exclusive vote, the candidates least approved are gradually eliminated until one is selected. If the appointment has to be made by the council the committee selects two or more candidates to attend the next meeting of that body, but probably recommend the election of one, so that this matter is generally a foregone conclusion when it leaves the committee.

Unmarried candidates between 25 and 35 years of age are preferred and they are usually required to live within the area of the local authority.

The above may be taken as giving the most common procedure in large boroughs, but every council is a law unto itself and numerous variations of the procedure indicated may occur.

It is safe to assume that merit, not influence, is the deciding factor in getting an appointment, but it is obvious from what has been said that candidates must not assume that their merits will carry weight unless they are strikingly exhibited. For general convenience applications should be very clearly written or typed on large-sized paper. The advertisement for the appointment gives the information which is essential, and failure to provide this, e.g., the age—may mean loss of the appointment. The essential information and special qualifications should be set out categorically, so that one application can be compared with another at a glance. It is naturally inferred by committees that a candidate who sends in a slovenly application will do her work in a slovenly manner.

As regards testimonials it is important to remember that these should be recent. Any old dated testimonial may lead to awkward questions, so it is wise to get special or re-dated ones for the occasion. Great names may impress some persons and some committees, but it is well to assume that what plain Mary Smith says after experience of the candidate's work carries more weight than what Lord This or the Bishop of That says after no

experience. Usually only three testimonials are asked for and it is a mistake to send in more. Frequently only one is read in committee.

The interviewing the candidates is the most important and to some the most trying part of the process. And here it is difficult to say much that can be of assistance. Knowledge of how to make the best of oneself comes by nature and improvement but it is not an art to be taught in a few words. Nervous candidates are certainly heavily handicapped, and such should be careful to avoid any conditions, such as fatigue and worrying likely to increase their nervousness. Members of the committee often unintentionally appear brusque and alarming; it is well to believe that they are doing their best to be kind and urbane.

It is wise to answer questions simply and straightforwardly and to avoid the errors of suspecting a trap on the one side or of talking too much on the other.

Canvassing is almost always forbidden, though it would give a better chance to the nervous candidate. Indirect canvassing, which unfortunately cannot be prevented, is far the most objectionable. When the Medical Officer of Health is willing to see candidates there is decided advantage in visiting him, though if he is wise he will avoid favouring any particular individual.

Seeing that a testimonial given after experience of a candidate's work carries very much more weight than one given by a teacher, or by a person—however distinguished—who has only known the applicant in a casual way, it is very important for any beginner seeking a municipal post to obtain some voluntary or unpaid municipal work in the first place. Some health visitors are allowed to take pupils, or to obtain the temporary assistance of anyone approved by the committee or Medical Officer of Health. But it will be still easier to find voluntary work under one of the numerous local associations which run infant welfare centres, in co-operation with the Medical Officer of Health. The pupil

or unpaid assistant attends the infant consultations and visits certain cases with or under the health visitor or superintendent. A testimonial from the superintendent of such centre will carry considerable weight.

It may be inferred from what has been said that the candidates with best qualifications for the work of a health visitor does not always succeed in convincing a committee of her superiority. It is well known in all spheres of life that there are no infallible tests of ability and character, so that the best committee with the best will to do right often goes wrong, especially if dominated by a self-confident councillor, who prides him or herself on being a judge of character. It must be with sorrow admitted also that there are sometimes committees which are not keen on getting the best health visitor possible, or who are more inclined to look on the outward appearance than to search for the soul within.

A very little thing may turn the scales in favour of one or another. Candidates then who are unsuccessful should never despair. If they are well qualified they are pretty sure to be selected after trying a few times.

CHAPTER IV.

COUNTY AND RURAL HEALTH VISITING.

EVERY newly qualified health visitor when applying for an appointment, wishes to know what duties may be allocated to her, and under what conditions she will work. In some cases a list of duties is supplied, but more often no information is sent concerning the appointment, and the candidate has to find from experience in the post the circumstances and conditions of her work. The organization of health work differs slightly in Metropolitan boroughs, and still more in towns and cities outside London, but the greatest variations are found in county and rural areas. The conditions of work must necessarily vary with geographical characteristics, transport facilities and industrial employment, and what is stated of one county may be inapplicable to another. County health visiting may be confined to rural areas, or to small towns with convenient railway connections, while in other districts rural and town work may be about equally divided. A rural area may be included within the boundary of an urban district or borough, so that a health visitor employed there would find that her duties were not limited to town work, but included also experience of country districts around. While it is not possible to give a detailed account of the organization of each county, it may be useful to sketch a general impression of existing conditions, in order that intending candidates may realize some of the advantages and drawbacks of these posts, when deciding between rural and town appointments. For rural visiting —though full of charm—is not all poetry !

Authorities.

Health visitors doing county and rural work may be employed by different authorities. For example, they may be paid entirely by a county council or by a county council and district council jointly, or again by a county nursing association. The difficulties of the second method will be at once apparent. Each council may be anxious concerning the division of the health visitor's time, lest she should give too much attention to the duties assigned by the other authority! It may seem unnecessary to advise health visitors to ascertain to whom they will be responsible, but cases have occurred where health visitors have been confused concerning payments by county councils and county nursing associations, and this should be guarded against by a definite understanding at the time of appointment. The authority advertising the vacancy should be the employer. In parts of Cornwall some health visitors are employed by the County Council and some by the Nursing Association ; there is a joint committee, but health visitors are responsible to the superintendent of the nursing association—even when employed by the County Council.

Salaries.

Recent advertisements have stated the following salaries :—

County Council of—

The Parts of Holland and Lincolnshire, £110, with £20 for the supervision of mental defectives.

Gloucestershire, Worcestershire, Essex — £150.

Durham ... ... £150 rising to £190 by annual increments of £10, to include uniform and subsistence.

Lincolnshire ... £150—£180.

Herefordshire ... £150—£180, by £10.

Leicestershire	...	£125—£140, by £5; War Bonus, £30.
Berkshire	...	£150—£200.
Bedfordshire	...	£160—£180, by £5.
Staffordshire	...	£170—£190, by £5.
Derbyshire	...	£170—£210.
Salop ...	...	£168—£240.

It is of interest to compare these salaries with those of counties near London—e.g., Surrey, £179 to £215. Superintendent's salary, £300.

Travelling Expenses.

Travelling expenses may be paid in several ways; £5 to £8 a year is usually the bicycle allowance, or the standard of payment may be mileage (e.g., Gloucestershire 2d. per mile, Worcestershire 1d.). Third class railway fares are paid as claimed, except where a definite sum is stated for this purpose.

Uniform.

"Uniform" may be that of a nurse or it may mean a coat and skirt. Frequently £10 is the uniform allowance—to be spent at the discretion of the health visitor. Laundry allowance has been given in some counties (e.g., Lancashire). In Warwickshire the uniform provided consists of two tailor-made costumes, four hats four blouses and one mackintosh or winter coat.

Holidays.

Many counties give four weeks' summer leave with Bank holidays. In some cases ten days are allowed at Christmas and Easter, with three weeks in the summer.

These holidays compare very favourably with those of large towns and Metropolitan boroughs.

Qualifications.

A glance at the list of duties carried out by some country health visitors will serve to indicate the thorough training necessary for this work, and it is a matter for

congratulation that many health visitors are adequately qualified. For example, in Surrey, practically all are fully trained nurses with the certificate of the Central Midwives Board and, in addition, that of a health visitor or sanitary inspector. On the other hand, in some counties health visiting is carried out by village nurses, and the county council makes a grant to the nursing association for the work done. The training consists of one year's preparation, and during that time the candidate obtains the certificate of the Central Midwives Board and a smattering of general nursing. Then she is qualified as a village nurse, and in return for her training, undertakes to serve for three years. She supervises the post-natal care of her own cases. The salary is about 27s. per week. In many instances village nurses have received more training than the minimum indicated above, and have attended lectures to help them further in their health visiting work, but it is deplorable that such inadequate training should be accepted, or that such totally insufficient salaries should be given. Village nurse health visitors are usually helped and supervised by health visitors of more thorough training, and they, again, are responsible to the country nursing superintendent who may not be experienced in health visitors' work.

Superindendent's Duties.

Most country health visitors are responsible to a superintendent health visitor (though in some cases to the county nursing superintendent) and upon the efficiency and consideration of the chief, depend to a large extent, the success and happiness of the health visitors. County health visiting presents special difficulties. Houses to be visited are often far apart; health visitors may be isolated and experience lonely lives, but when the superintendent is not exacting as to the number of visits paid, and takes such an interest in her staff as to arrange meetings for them, many of the disadvantages may be overcome.

In some cases a health visitor is superintended by two officials, one for school work and one for infant welfare; this arrangement may be fraught with difficulties if each superintendent thinks his or her department the more important. A health visitor might legitimately concentrate as far as possible on infant welfare in the diarrhœal season, but this arrangement would not secure a long report of school work for the superintendent dealing with that department.

Duties (General).

In different counties and rural areas health visitors are variously employed. As the distances to be covered are usually considerable in proportion to the number of houses visited, it ensures economy of time if arrangements are made for one official to carry out several duties. Some health visitors will perform all the work mentioned below, while others will do only one section (e.g., tuberculosis supervision). In larger towns there is always a tendency to specialize in one department of health work. Thus health visitors may do infant welfare work only, while their colleagues visit cases of tuberculosis; the school work will be carried out by school nurses and the inspection of midwives by doctors or highly-trained nurse midwives. But usually in a county or rural area the duties are more diverse. A candidate for a new appointment, when recounting her experience, will probably be able to show a more impressive list of duties performed, if she has worked in a rural area rather than in a town; this does not necessarily mean that she is better qualified for health work, but it is a point to be borne in mind in view of applications for subsequent appointments. Some councils may prefer candidates who have specialized in one department, but many prefer those who can prove more diffuse experience. The following list includes many of the duties performed by county and rural health visitors:—

(1) Visiting infants and children up to 5 years of age, and organizing maternity and child welfare centres.

(2) Visiting tuberculosis patients, and attending dispensaries and committees.

(3) School nursing, including attendance at schools and clinics; also visiting school attendance work.

(4) Inspection of midwives.

(5) Visiting mentally defective cases.

(6) Supervision of orphan children of soldiers and sailors and boarded-out children.

Office Work.—Information concerning work to be done is usually sent by post from the central office. In some counties cards are forwarded perhaps twice daily, while in others the work is dispatched once a week. Health visitors usually are free to arrange their visits as they find best, and in some instances they hold their own cards when completed after visiting. In other cases their records are sent weekly or fortnightly to the chief office for inspection and for the transference of particulars into registers, and then the records are returned. Reports of certain cases may have to be forwarded immediately after visiting. In most instances county and rural health visitors have no office. Communications from the superintendent are then received at their private address. The disadvantages of this arrangement are at once apparent. The health visitor's house cannot be the change from work which is so desirable, since her reports must be written there, and if she is a keen worker with an enlarged conscience and a distorted sense of duty, the arrangement may provide unlimited opportunities for overtime employment. Inevitably, health visitors must on occasions work longer than their specified hours, but even an exacting chief or the pressure of work should not cause a woman to carry her duties persistently into her spare time. When she does so, however noble her intentions, the result will be impaired efficiency, if not complete breakdown.

Since the health visitor's house is also her office, she is subject to invasion by mothers living near. If she does not keep her existence shrouded in mystery (a difficult

task in a rural area !) she will have many callers seeking her advice in the evening and at the week-end. Now since every health visitor wishes to be a real friend to the people, she is willing to help in every way possible, but she should be able to let the mothers know when she can be conveniently interviewed *apart from her private address*. The disadvantage of the system is realized when a health visitor, remaining in bed with a cold one Sunday, is there "run to earth" by an eager mother, agitated because the family hair-brush cannot be in two places at once ! A child is entering a sanatorium and requires a "trousseau" of its own !

If a health visitor has an office of her own (which might conveniently be a welfare centre) she can then attend at stated hours to meet inquirers. She is no longer under the necessity of storing official records in her lodgings (a procedure undesirable owing to lack of space, equipment and privacy), and when she has turned the key of her office she is free from the suggestion of work. Rural and country health visitors sometimes share offices or buildings with other officials, and though not undertaking the same duties, these colleagues provide, to a certain extent, comradeship in work. They are usually extremely helpful to new comers, and willing to utilize opportunities for co-ordination of work. It frequently happens that such colleagues in the office are men—in which case the health visitor will be found interviewing mothers in the porch, or work will be suspended at all the desks while the gentlemen retire ! Needless to say the health visitor's office should not be the "dumping ground" for bad food, yet such has actually been the case !

A health visitor may gather a great deal of practical knowledge from working side by side with other health officials, and though she will naturally concentrate on her own department, she will gain valuable insight into public health work as a whole. Thus a newly-qualified health visitor may gain a wider view of the health service

if she is in a small town or rural area, than if she takes a London appointment where the health department is divided; but she will lose immeasurably in comradeship and experience, if her appointment does not involve working with others in an office.

Travelling.

The greatest difficulty of county and rural work is travelling. And here no two counties present exactly the same conditions, and while one health visitor may find herself physically exhausted by her first visit, another may get through a whole day without more fatigue than is experienced by a town worker. The geographical characteristics of the country are here the main factor and, depending on these, the channels of communication. In considering usual means of transport, the railway is at once suggested. There are some fortunate districts where, owing to industrial activity, the railway service is excellent, and county health visitors can work one town each day, returning in the afternoon to their homes with little waste of time and a good list of visits accomplished. This is the case in some parts of Northumberland and Durham, and county visiting then approximates to town work in character. But often in country work the train service is not so obliging! In the first place, the railway line usually leaves untouched a vast area of the district, and that the area where transport by road is most difficult. Then, even where the railway serves, the trains are at most inconvenient hours. The health visitor may have to get up early and return late, and having spent tedious intervals at minor junctions, may only have accomplished a few visits in the day. In winter, visiting after dark in rural areas is impossible, and there is no comfort in tiny railway stations for the health visitor while awaiting trains.

The most usual method of travelling is on a bicycle. This is sometimes provided by the council and some-

times by the health visitor. It is of course possible by cycling to cover longer distances than could be undertaken on foot, but in any case there is often great expenditure of energy before the visit is begun. The health visitor has to carry out delicate interviews requiring all her resources, when she is physically weary with the journey to the house. Moderate exercise is of course a great advantage, but in county and rural appointments it is difficult to achieve an adequate number of visits—or even to accomplish the most urgent work—without fatigue. It must be remembered, too, that a day's hard cycling will probably be followed by more cycling, and so for the whole week until Sunday, excessive fatigue not being counteracted by intervening days of rest. There are counties where the roads are good and cycling is easy. There are others where only the high roads are in good repair, and where hills add to the difficulties of the cyclist. In some districts, owing to the hilly nature of the country, cycling is almost impossible.

In summer time town dwellers passing through quiet villages think how delightful work must be in the beauty of the country; but let them accompany a health visitor in her visits in a northern district, and they will speedily modify their opinion! First, there is difficulty in finding the required dwellings. The visitor has to make her way to remote homesteads and isolated farms—sometimes in districts where there are miles between the houses, and no convenient places for directions as to route. Before setting out she will have studied the map, and if sharing an office she will have received instructions from her colleagues, but alas! for the uninitiated in wild parts of the country. She will find no signpost, no friendly pedestrians, and no labelled farm houses; she will discover paths not indicated on the map, and find her own route is off the road altogether. She must perforce leave her bicycle by a wall (hedges do not grow in these parts), and climb over by footholds of projecting stones. She must pass through several stretches of enclosed pasture

land and climb sundry other stiles, making her way to the gate ahead. In the yard beyond the gate she will progress more slowly—owing to a collection of pigs vastly interested in her ankles—and when finally she knocks at the door she may hear that Mrs. B. is gone out for the day! Then the health visitor will feel suddenly tired, but will do her best to accomplish the object of her visit, and will probably seek instructions as to the next place of call. She will learn of a "short cut" over the fields—"sometimes a little damp at the bottom," and set out once again. There is no path, but by carefully following instructions, she will see her goal at last, only to find that the "dampness at the bottom" is a veritable "slough of despond"! She will plunge through it desperately and arrive muddy but triumphant at the required house. After the visit comes the long journey back to the bicycle, and a still longer road to her next case, and thus to a fourth and fifth house. Lunch may be eaten in a cart shed, and soon it is time to return home—and only a few visits accomplished!

In summer the heat may be trying on roads where no shade is to be found, and there is always a degree of uncertainty as to what may be the weather before the end of the day; but the greatest difficulties are to be met with in winter. So strong are the gales in some parts (e.g., Lincolnshire) that cyclists have been blown to the ground. The savage weather of hilly districts in Lancashire is well known, where the continued rain, with bitter winds, makes even walking a trial. A rural health visitor may set out with her route carefully planned and then find her road is blocked by snow, and she may be forced to return without accomplishing a single visit. In several counties (e.g., Surrey), health visitors have a provisional programme of indoor work for bad weather, but in some districts if they were to refrain from visiting on stormy days they would hardly ever go out of doors!

Certain county health visitors once provided (not out of salary!) their own motor bicyles. The arrangement

—apart from the financial aspect sounds excellent, but such was the district that the cyclists had to dismount at every hill in order to push up the machines.

Motor scooters are now suggested, and may be of considerable use.

The carrier's cart may occasionally prove a convenience in rural visiting, but usually a cyclist can accomplish the same journey in much less time.

Amongst other methods of travelling may be mentioned the friendly milkman's cart; the doctor's motor for school inspections; or a conveyance provided by the council. When other officials are likewise visiting in the country, it is often possible to find a seat in their taxi. It happened once that a motor was not forthcoming for a hilly route, so a carriage and pair were substituted. The officials visited the hospitals and farms required, leaving the health visitor to continue her journey alone. Judge of the amazement of the villagers when they beheld the imposing carriage (usually reserved for weddings and funerals) and imagine the increased value of the health visitor's advice in consequence of the equipage! A council may possess a conveyance for other purposes and this may be lent for health work on occasions. One health visitor reported that the most exciting day she ever spent was in a council dog-cart behind a fire-engine horse—for it performed circus tricks at every gate!

Meals.

Food is a real difficulty in country visiting. The health visitor must prepare her own lunch before starting, and being frequently not hungry at the time but in a hurry to set off, the meal is a slight affair. (It may be suggested that workmen suffer from the same disadvantages, but it will be remembered that the labourer's *wife* packs up the lunch, and equally obliging landladies cannot always be found!) The next problem is where to eat the meal. Picnics are delightful in summer, but imagine a rain-soaked health visitor in winter time vainly

looking for a shelter ! the writer once "trusted to luck"—or rather to a wayside inn (known to be inhabited). She there found the fire gone out, no tea possible, and had to make a meal of bread-and-butter and mineral waters. In place of the hoped-for smell of eggs and bacon, only stale tobacco scented the air, and the room would have supplied material for many a hygiene lecture.

Subsistence allowance at the rate of 2s. 6d. a day when away from home is usual (though not in Durham) but this does not overcome the difficulty of meals where no restaurants or inns are to be found. Every health visitor will make light of occasional hardships, but regularly to miss suitable food and any place of rest at midday is to court disaster. When duties include attendance at schools, clinics and welfare centres, there should be some degree of comfort for a meal, but in any case health visitors should conscientiously prepare for themselves adequate nourishment—just as if it were for someone else. They should also on engaging rooms arrange with the landlady for a substantial evening meal. Health visitors may find after a time, that it is possible to have dinners with friends in their district, or cottagers may undertake to provide meals; but the uncertainty of the daily programme makes such arrangements awkward. In rural areas where transport facilities are poor, health visitors may easily suffer from exposure to weather, insufficient food and excessive fatigue. Yet such is the charm of the work that there are health visitors now employed in easier areas who are only waiting for the means to buy a motor car in order to return to their old districts.

Maternity and Child Welfare Work.

Visiting is carried out under the Notification of Births Act, and the health visitor arranges to call when urgent matters take her into that neighbourhood. Country babies are usually breast-fed but the mothers are behind the times in most matters. For example, they feed their infants too frequently, and if artificial feeding is necessary the health

visitor's nightmare—a long-tube bottle will probably be produced! It takes much perseverance to carry out pioneer work—to persuade isolated mothers that irregular and night-feeding are not desirable, and the health visitor may experience many failures before she finally succeeds. Similarly with regard to clothing: stiff binders are still in evidence; cotton or linen shirts are found, while short sleeves are the only fashion known! then the baby usually sleeps with its mother, and the windows are of course securely shut. Country babies are often healthy at birth and if they are born in the spring or summer they usually make good progress; but since they are normally indoors all winter, they may be found as anæmic and rickety as any town child. One farmer's wife was greatly puzzled over the death from bronchitis of her seven months' old infant. "How he came to get it, I don't know" she exclaimed, "for he had never been out of the house in his life!"

Health visitors invariably find that mothers reflect the methods of the nurse or midwife. When a mother is confined she has to submit to the attendance of others, and has leisure to observe what is going on around. If a modern midwife begins work in a rural area, the health visitor will find her task much simpler. Even if the mother adopts her own methods after the midwife has left, she is in a much better position to appreciate the health visitor's advice. But in some places the midwives are *bona fides*, or have long since received their training, or perhaps "handy women" do the work under the supervision of doctors, and it will readily be seen that a health visitor may be quite alone in her views on infant care. She will go very gently in consequence, and however great her enthusiasm for reform, she will understand that everything cannot be altered at one visit. She will try to gain the confidence of nurses and midwives and overcome any suspicion with which semi-trained people may regard her, and whilst definitely clear as to the reforms required, she will be very sympathetic about the

old methods. She will already have learnt how to express a contrary opinion without arousing animosity, and she will be sure to praise what is right as well as try to change a little of what is wrong.

With regard to the older children, they are usually fairly sturdy, but when defects are found, they are often more marked than in the case of town dwellers. For example, a case of rickets will probably not receive attention as early as in a town, but when discovered will be found in a marked degree.

In the country housing is a well-known difficulty. Cottages and farms are frequently in bad repair, and it is not easy to get defects remedied. When the local council is composed chiefly of property owners, it may be extremely awkward to carry through reforms. The county health visitor will report defects to the chief, in order that an intimation may be sent to the local authority concerned.

The water supply of rural areas does not compare favourably with that of towns, and similarly in the case of sewage disposal; but where country dwellers gain immeasurably is in the fresh air. When mothers keep the little ones indoors, they are depriving them of practically all the advantages of country life. The food supply in rural areas is not as good as in the towns, except for milk and eggs, and this excellent diet is usually despised by every country child.

Maternity and Child Welfare Centres.

No institution could be more helpful to a rural health visitor than a welfare centre. It creates a public opinion about infant care, and the health visitor is no longer fighting her battle alone. When the most enthusiastic mothers meet together and learn that others are also trying to follow instructions, they are fortified against criticism and persuasion from friends. Then new mothers attending the centre see the health visitor established as the recognized authority on babies, and are more inclined than pre-

viously to follow her advice. Centres have sometimes been opened by the health visitor without medical attendance. Then later arrangements may have been made for a doctor to conduct consultations—frequently at first a private practitioner who kindly gave his services. Now, of course, medical attendance is adequately provided in practically every area, and the health visitor has a strong ally. Moreover, she feels the advantage of being able to discuss difficult cases with the doctor and to get advice. Visitors who previously worked their districts without welfare centres know how much easier it is to get results under modern conditions.

The County Council frequently opens welfare centres at the request of their own health visitor, or following a representation from a local committee. In Surrey the County Council will establish a centre where an attendance of twenty is guaranteed. Frequently persons interested and members of the local committee will help as voluntary workers. It is very rare that a sufficient number of paid officials are available for rural welfare centres, but amongst voluntary helpers there are sometimes trained women. Concerning work with voluntary assistance health visitors give various reports, and whereas one may find everything to go smoothly, another may tell of constant worry. In fact, one superintendent stated that nearly all her time was occupied in trying to overcome friction between paid and voluntary workers! In some districts health visitors arrange teas after the centre meeting is over, and persuade the medical officer of health or other official to meet the voluntary helpers and have informal talks. In this way the ethics of health work can be easily explained without undue dictation from the health visitor.

In rural areas welfare centres often show a completeness which compares well with town organizations. The number of babies is not so unwieldy, and thus it is possible to develop different branches of the work. Centres are usually open on one afternoon a week, and

weighing then takes place. Doctor's consultations may be held weekly or fortnightly (and in a few instances—alas! quite irregularly), but homely talks or lectures are usually given in addition. The health visitor may lecture, or she may arrange for other people to give mother-craft talks—and, of course, she must see that there are sufficient helpers to look after crying babies. Demonstrations are also given, and school girls attend the centre to learn how to bath and dress a baby. These children also make infant's garments in their schools, while boys in carpentering classes construct cots and other useful articles.

The supervision of the orphan children of soldiers and sailors and of boarded-out children is sometimes included in the duties of a county health visitor, and this arrangement is usually quite convenient, for these cases can be more easily supervised when seen at welfare centres. Where ante-natal clinics are established, midwives are encouraged to send and bring their patients.

Tuberculous Work.

In many districts there is no single authority for dealing with tuberculosis. Some local councils provide their own tuberculosis nurses, while county visitors supervise only the cases attending dispensaries. This inevitably leads to duplication of work, for a newly-notified patient may be seen at home by the local health visitor, and if at the time of notification he has been referred to the dispensary, he will also be visited by the county official. A local health visitor will have done her best for her patients when she has persuaded them to attend a dispensary, and then, alas! she will lose sight of her cases. From the patient's standpoint, too, the arrangement is undesirable. When encouraged to attend a welfare centre or a tuberculosis dispensary, the inevitable question of the patient is, "Will *you* be there?" Now a tubercular patient, above all, needs consideration, and if he can meet at the dispensary the visitor he has already come to know, he will have much

more confidence in the whole arrangement. In some areas local authorities have already handed over to the county the tuberculosis work, and this has saved much duplication and annoyance. In addition to visiting patients, county health visitors attend at dispensaries. The duties there include organizing the general arrangements, clerical work, weighing, demonstrating the use of thermometers and helping the doctor in every way possible. Health visitors also see to the provision of paper handkerchiefs and sputum flasks, and teach the patients how to do the best for themselves and prevent infection to those around.

In some counties reports of visiting in connexion with tuberculosis have to be written in triplicate, copies being sent to the central office, local authority and dispensary. This means that each case entails much clerical work for the health visitor — type-writing machines not being supplied.

School Nursing.

This branch of county and rural health visitors' work includes inspections at schools, visiting in the homes, and attending treatment centres.

Inspections at school may be carried out alone or with the medical officer or school dentist. In the first case, the nurse inspects for cleanliness chiefly, and this visit often gives the most accurate impression of the scholars. It is usually a surprise visit, and therefore the children have not been specially cleaned up for the occasion! The nurse makes a report of all verminous children with a view to taking the necessary steps for their cleansing.

On other occasions she visits with the medical officer, and then her duties are more varied. Her task is not the most easy in the world, for she must consider the doctor, the parents, the children, and of course the school teachers! She must organize the inspection and see that the room allocated for the purpose is suitable in every way. It is sometimes difficult to secure a room where the lighting is good and the heating adequate for undressed

children, and yet she must not be exacting in her requests, for a medical inspection should not upset the régime of the whole school. Many teachers are most helpful on these occasions, and when once their co-operation is secured the nurse's difficulties are greatly modified. The mistresses of senior classes will often lend big girls to help with the undressing and dressing of the young children (when the mothers are not present), and this is of tremendous value to the nurse. If dealing with any but small numbers, she cannot carry out innumerable duties in addition to general supervision. The parents who attend inspections are sometimes inclined to be on the defensive. Since the introduction of welfare centres this tendency has disappeared to a certain extent, for the mothers have become accustomed to medical examinations; but there may still be parents who look upon inspections with suspicion, and however busy the nurse, she will treat everyone with the courtesy she would extend to her own private friends. Then, again, by her considerate treatment of the children, the mothers will gain confidence and be inclined to carry out instructions. This does not mean that the neglectful will escape reproof or that discipline will be relaxed among the children, but consideration will be usually repaid in the corresponding courtesy of the parents.

The school nurse will obtain the history of each child and do the preliminary clerical work. If she is also a health visitor, she will find no difficulty in asking questions conversationally without waste of time. The children to be examined will be entrants, leavers and special cases. The last may be children previously found to need attention, or scholars selected by teachers for some particular cause. The children must be undressed and ready for the doctor the minute he is disengaged, but must not be without clothing longer that is absolutely necessary. Notes are made of the clothing worn. It usually happens that the children have had a bath the previous night and a complete change of gar-

ments for the examination. Sometimes a further step is taken and new clothes are bought. In one district, during intensely hot weather, most of the mothers invested in a pair of new red stays for the children, and the poor mites, already deplorably over-clad, were, in the words of the medical officer, being "slowly converted into soup"! He therefore excused the children this additional burden, and made the mothers carry home the stays, in this way "brightening the whole neighbourhood" with little spots of red.

The next duty of the school nurse is to weigh the children. It is a great help if teachers can be spared to undertake this part of the work and also the measuring. The nurse is then able to devote more attention to the tests for eyesight and hearing. Much patience is needed in testing little children who can hardly read, and a considerable amount of time must be spent in this way.

Frequently only one room is available for all purposes —for waiting, for the nurse's inspection, and for the medical examination, so each department of the work must be carried on without noise. When a school nurse accompanies a dentist for inspection only, her duties are usually mainly clerical.

Home Visiting.—The school nurse must visit the homes of children found to be suffering from defects, and make arrangements for treatment. School clinics provide treatment for certain diseases, and in some cases are equipped to deal with practically all defects found. In other districts only a limited number of diseases can be treated, and other defects must be attended to at hospitals. The school nurse gives instructions to the parents concerning cleansing in verminous conditions, and reports the need for disinfection of bedding, &c. It is often more difficult to persuade mothers to cleanse the children than to effect this at a cleansing station or school clinic, but when the mother has no trouble over the condition, she is inclined to make no effort in the home towards cleanliness and the children get repeated reinfections!

The nurse arranges for impetigo and ringworm cases to attend the clinic, and ear and eye patients may also be treated there or go to hospitals. Simple though this sounds, in practice it may be extremely difficult to arrange. Everything depends on the journeys involved, and the facilities for travelling. Cottages are frequently away from a road, miles from a village, and an impossible distance from a railway station! If a train service covers the journey to the town where the hospital is situated, there is the difficulty of getting from the cottage to the station. Carriers' carts are sometimes available, but when the carrier's day is Tuesday and the ear day at the hospital is Wednesday, it taxes all the ingenuity of the health visitor to make arrangements. Then the financial aspect has to be considered. In some counties there are care committees which provide funds for travelling, but this arrangement—because voluntary—has many drawbacks. Treatment must frequently be prolonged in order to be thorough, and in this way a child may prove a very great drain on the funds—a burden out of all proportion to the money available. Then when a local committee takes an interest in a case, the health visitor may be expected to make frequent reports, and to give more time and attention to the child than her other duties will allow. In some counties (e.g., Warwickshire) fares are paid by the County Council. Children suffering from ringworm, and all other cases needing to attend frequently the curative centre, are in this way assured of adequate attention.

When the mother has been persuaded to give her consent to treatment, and a convenient means of transport has been devised, there still remains the problem of younger children at home. The health visitor will do her utmost to encourage the mother to make her own arrangements for the household, but a friendly neighbour is not always available to take charge at home or accompany the child. In the cases where no one has been found to go with the patient, the health visitor must undertake the task. This usually entails a long absence from home, and the

health visitor will spend the whole day over this one scholar and record one visit! This is immaterial where the superintendent has herself been a health visitor and understands the conditions of work, but it is very discouraging if the number of visits constitutes the standard of achievement and a high average is expected.

Another duty, when visiting in the homes, is the swabbing of diphtheria contacts. Some medical officers give instructions for both nasal and throat swabs, some for one or other method.

Treatment Centres.—School clinics vary a great deal in the scope of treatment. Some attend to practically all conditions—from verminous heads to minor operations, while others deal chiefly with skin diseases such as ringworm and impetigo. It seems regrettable that highly trained workers should spend hours in dealing with uncomplicated verminous cases, yet such is the arrangement in certain clinics. School nurses experienced in this department do not wear flowing ends to their caps!

Much time is usually devoted to skin diseases, because a large proportion of children requiring treatment are found to be suffering from these conditions. In many clinics external applications are used for ringworm, but in others patients are referred to hospital for X-ray treatment.

Ear discharges are frequently treated at clinics, and also minor eye troubles. The whole work of the clinic is under the direction of the medical officer and he usually selects a few special cases for treatment by himself, the rest of the work is done by the school nurses. Children found at the schools to have defective vision are sent to hospitals or the clinic for testing. If the latter provides equipment for this work, it is of course carried out by the doctor, but the nurse may help with clerical work and follow up the case. When eyesight is tested at the clinic, and prescriptions are sent direct to the optician, the whole matter is very much simplified.

In rural areas it is not usually possible to conduct operations for adenoids and tonsils at school clinics, and

cases requiring operative treatment are referred to private doctors or hospitals.

Dental Clinics.—In different parts of the country school dentists are being appointed, but still in many areas children with defective teeth cannot be treated by the county. When provision is made for dental treatment, equipment may be provided at the clinic, or the dentist may visit schools and there have the use of a room when required. Needless to say, it is more convenient for the dentist and nurse, if all treatment is carried out at the clinic. When cases are noted at the inspection as requiring attention, parents have the option of making their own arrangements for treatment. Failing this the nurse gives the child an appointment with the school dentist. It is not usually sufficient to send notices by post, the attendance will be very much more satisfactory if the nurse has visited the home and reminded the parents of the day and hour for treatment. The nurse's duties include clerical work, the sterilization and care of instruments, &c., the preparation of fillings, and the general management of the children. All this demands constant watchfulness on the part of the nurse. She must have everything in perfect readiness for the dentist and hand what is required; she must "clear up as she goes along," so that sterilized instruments are always available; she must keep up her supplies of hot and cold water, and above all, she must look after the little patients without "fussing." Children apart from their parents are usually quite manageable (there are, alas! a few exceptions) but a waiting mother often imparts a degree of nervousness to the child, while the appearance of a dental surgery is not always reassuring. Remembering all this, and possessing a deep liking for people as well as for skilful work, the nurse will have a friendly smile for both mother and child. After the extractions (and what a number are accomplished at one sitting!) the nurse must have another patient ready for the dentist, while she looks after the first child. She will not detain the child in the surgery longer

than is necessary, and knowing that the little one is in pain, she will be invariably kind. It is a great advantage if patients who have received treatment do not go among waiting children, but in any case the nurse will be careful to remove all traces of the fray!

Other Duties.—In addition to the duties mentioned, health visitors will be called upon to visit special cases—e.g., infectious disease, puerperal fever, ophthalmia and measles, and they may be required to swab for diphtheria in schools as well as in the homes. Surrey health visitors have had a variation of duty when accompanying rabies patients to St. Thomas's Hospital. Occasionally school attendance work is included in school nursing, but when there are other more urgent duties, this seems to be a mistake. If attendance work by health visitors were limited to children reported sick, there would be reason in the arrangement, but when trained women spend their time visiting scholars absent for half a day, the arrangement is obviously futile. This was the method of one district during the War, when children were absent on account of the father's leave, and it is hoped that it was merely a war-time measure, now superseded by more reasonable arrangements.

Inspection of Midwives.

It is generally held that midwives should be inspected by medical practitioners, and where this is impossible by midwives who have had extensive practice. In many counties special inspectors of midwives are appointed and in others (e.g., Warwickshire) health visitors carry out the work. The duties include inspection, investigation and education. Records and bags are inspected, cases of illness and complaints, &c., are investigated, and practising midwives are helped and taught by the inspector. In county and rural areas there are many "bona-fide" midwives—frequently quite elderly—and it is no easy task to help forward their education. The inspector must have a methodical mind and clear way of expressing herself. She may at any time have to report a case to the Central Midwives Board and

give evidence. When an inspector has an extensive area to supervise, she cannot afford to waste time by calling on midwives to find them not at home, so she frequently writes making an appointment. Now this obviously means that the midwife is prepared for the visit, and the inspector may not get a fair idea of the normal condition of things. Inspectors, knowing the difficulties of rural midwives, and understanding that their livelihood is gone if they are crossed off the Roll, take infinite trouble to improve matters before finally reporting them to the Central Midwives Board. Flagrant instances of neglect must of course be dealt with drastically, but the inspector will carefully go into all the circumstances and ascertain what are the facts and what is merely stated by friends and neighbours, before reporting the case. Every health worker will appreciate the difficulty of such investigations, for it is well known that "garbled stories" are repeated by mothers without any malicious intent.

Mentally Defective Cases.

In the duties of county and rural health visitors, the supervision of mentally deficient persons is frequently included. The object in visiting is to ascertain that these patients have adequate care, and to arrange for institutional treatment when desired. There are cases where, owing to the helplessness of the patient, or the claims of other children, the patient should, in the interests of the family, be taken from home. Yet the very dependence of the afflicted child has brought out untold self-sacrifice on the part of the mother, and she is exceedingly reluctant to allow the child to go away. The health visitor must do her best to show the mother every point of view, and though it may take some time, the parents may finally consent. It is in the interest of the patient, the family and the community that adolescent girls who are mentally defective should receive absolute protection. This is almost impossible to arrange in working-class homes, and such children should be admitted to suitable institutions. In all cases, the greatest happiness to the child is secured in institutional treat-

ment, and the health visitor, when talking to parents, will point out the expert care and teaching supplied there. She will remind them of the pleasure this little one will derive from the accomplishments learnt, and the happiness of working and playing with other children of his own capacity.

Certain particulars will be required in all cases and differing in each county, but the health visitor will ascertain as many details as possible without seeming too inquisitive. In one county, the visitor reported that only the names and addresses of patients were supplied to her; so that she might inquire for "little Jack Smith" and find he was an old, old man! She was also expected to ascertain particulars as to clothing, and when she conscientiously inquired about the number of stockings possessed by the patient, the mother retorted "and what have his feet got to do with his head?"

It will be readily understood that the life of a county or rural health visitor is full of interest and charm. In common with town workers, she will be dealing with people—endeavouring to carry out her advice, and this type of work by its very difficulty is full of fascination. She may work her hardest and get no result, for the mother must be her executive, and it is infinitely easier to do a thing herself than to persuade someone else to do it. But she will have opportunities for practical measures at the school clinics, and what a relief it will sometimes be to turn up her sleeves and get to work! There is much variety in the life of a rural visitor, and this will stimulate her interest and keep her mentally alert. She will work in the fresh air—in all the beauty and quiet of the country—and unless she is over tired she will enjoy both her journeys and her cases. There will be the disadvantages of the absence of comradeship in her duties, loneliness socially, and the lack of good lectures and entertainments, but when once the health visitor knows her people and has gained their confidence, she will find that all drawbacks are forgotten in the happiness of her work.

CHAPTER V.

MATERNITY AND INFANT WELFARE CENTRES.

(1) Medical Officer's Duties.

(A) *Infant Clinic.*—In considering the accommodation, equipment and staff of an infant clinic its main object must be kept in view. According to the memorandum issued by the Ministry of Health in 1919, "an infant welfare centre is primarily an educational institution providing advice and teaching for the mothers in the care and management of infants and little children, with a view to maintaining them in good health. Its essential function is to supervise the healthy child rather than to treat the sick, though the incidental treatment of simple ailments may be included within its scope."

The same room will probably be used as *consultation room* for the infant clinic and ante-natal clinic. It must be well lighted, both naturally and artificially; be properly heated—a gas stove is the most convenient method; there should be adequate lavatory and sanitary accommodation, including provision of hot water; for furniture the only requisites are a table with drawers, three or four chairs, a clinical couch and a side table or cupboard.

The room should communicate directly with the weighing room, so that children are not exposed when being brought in undressed after weighing, to see the doctor.

The selection of a medical officer is most important. "The centre is worth as much as the presiding physician" (Dr. Budin). Sometimes the medical officer of health

acts as medical officer to the clinic. If he has had special experience at a children's hospital and has kept in touch with clinical work, no better arrangement could be made, for no one is more likely to appreciate justly the relative importance of prevention and treatment. But generally speaking the whole-time medical officer of health has lost—if he ever had it—his interest in clinical work and personal dealing with children, and has neither time nor inclination for this work. In large towns there is no difficulty usually in finding a specialist in children's diseases who is glad to have an opportunity of studying the healthy child, and the first beginnings of nutritional disorders. There are many women doctors, both in general and consulting practice, who devote their time specially to infant welfare.

In any case the medical officer must not be simply any qualified practitioner. He or she must have given special attention to and had special experience in the study and care of infants. He must also duly appreciate his relations with the medical officer of health on the one hand and the health visitor on the other. The former will be his administrative chief but will not interfere in his dealings with mothers and their children unless the clinic doctor should run counter to some recognized principle of the health department. To avoid misunderstandings he should communicate with the medical officer of health directly by letter, and not by messages sent through the health visitor. He will necessarily lean very much on the latter, who will know from personal observation much about the work which he can only learn at second hand; he will of course then cultivate friendly relations with her. He will instruct her as to children who need to be visited at their homes. Consultations are held every week and the infants are brought in to the doctor by the mother as soon as they have been weighed. It is best that the health visitor in whose district the mother lives should be present while the doctor examines the child, but often the strength of the staff will not allow of this, and as

the doctor should write down fully what he finds, it is not absolutely necessary.

It is most important that the doctor should make full notes on the case paper both as to conditions found, and especially as to any directions given, and when any milk formulæ are prescribed a copy of the formula should be entered on the case paper. This will enable the health visitor to explain to the mother how to carry out the doctor's directions.

A thorough examination of the child should be made on the first visit; if it is found in all respects satisfactory the doctor need not always see it again every week even though it be brought to the clinic weekly to be weighed. There are decided advantages in weekly attendances, as the weekly habit is easily formed, while it is difficult to keep up regular fortnightly or three-weekly visits; but children who are doing well need not come into the doctor every time they come to the clinic. Children under six months should be seen very frequently, and those under one year once a month.

It is most important that the doctor should both be regular and punctual in his own attendance and also that he should so arrange his time that he will not be hurried. A hurried doctor means a hasty and peremptory manner. Affability is desirable on all occasions, but it is essential at an infant clinic. Mothers will not bring their infants to be advised by a man or woman who does not treat them in a kind and sympathetic manner, so that the whole success of the clinic depends on this personal factor.

The question of the extent to which remedial treatment should be given is not altogether an easy one. Anyone who has visited the infant consultations held at Fécamp and other places on the Continent, must have been impressed with the advantage to the medical officer of being able himself to prescribe for the minor ailments which must inevitably arise from time to time. As a specialist he probably feels that he can diagnose and treat

the infant's disorder better than a general practitioner and will probably give it more attention than it would receive at an out-patient department. But great as are the advantages of giving treatment the disadvantages are greater. It is important to gain the goodwill of the medical practitioners in the district, and the giving of treatment is sure to arouse the hostility of many. But an even more serious objection is the fact that if mothers find that they can have their children treated free at the clinic the number who come for this purpose will soon exceed that of those who attend for advice or nurture only, and the main aim of the clinic will be gradually lost sight of. Those children who need medical treatment should be referred to their own medical attendant if they have one, or can afford to pay one; if not the doctor should give a card of introduction to some hospital surgeon or physician with whom he is in touch and who he knows is interested in such cases. Only such minor ailments as constipation, slight umbilical hernia, and intertrigo should be treated at the centre, in other words those ailments for which the ordinary working and middle class mother would rarely seek medical treatment. In this way the local practitioner can be assured that the clinic brings him more practice than it takes away.

(B) *Ante-natal Clinic.* — The main function of the maternity or ante-natal clinic "is to advise expectant mothers in matters relating to their health, primarily in regard to conditions directly associated with pregnancy, but also as to general ailments which indirectly affect their physical welfare" (Memorandum of the Ministry of Health, 1919). Unfortunately women do not generally recognize the importance of medical examination with a view to detecting early symptoms of disease and physical defect which may seriously militate against a successful delivery and prejudice the after health of mother and child. Thus the first difficulty is to induce expectant mothers to attend the clinic. This can best be done by securing the

goodwill and co-operation of midwives and general practitioners, especially the former. The local midwives should be invited to bring their patients to the clinic and to be present during the examination. They should be informed of defects discovered and measures recommended. If there is a local midwives' society it should be approached by a member or officer of the child welfare committee and co-operation invited. If no society has been formed an effort should be made to try and start one, and to ensure from the first friendly associations.

The expectant mothers must be treated with the greatest consideration. No internal examination should be made unless it is deemed essential in the interests of the patient, and her willing consent has been obtained.

The clinic should be under the *management* of a qualified midwife, who is preferably one of the health visitors. Other health visitors will find it easier to get mothers in their district to attend if they bring them personally. If the midwife's co-operation has been secured, any home visiting that is requisite should be carried out by her, if she is able and willing; otherwise the health visitor must undertake this duty, acting as far as possible in conjunction with the midwife.

The *premises* used will probably be the same as those provided for the infant clinic (see p. 72). All that is requisite is a consulting and waiting room with suitable lavatory and sanitary accommodation, and either a dressing room or screens, to avoid delay in admitting patients. The consulting room should contain a writing table with drawers, two or three chairs, and a couch for vaginal and abdominal examinations. (For the apparatus required see Appendix V*a*.

The *medical officer* should have had special experience in midwifery and diseases of women; if such a specialist cannot be obtained arrangements should be made to refer difficult cases to the obstetric physician at a neighbouring hospital, and the medical officer should take a course at the same or some other hospital. It is better that the

medical officer should be a woman, and should not be in general practice in the neighbourhood. However capable the medical officer she will probably find great benefit in being in close touch with a hospital, both for assistance in diagnosis and in case operative treatment becomes necessary.

The medical officer will probably hold weekly consultations. She will at the first attendance make an examination of the mouth, heart, lungs, legs (for varicose veins), and abdominal organs, and test the urine. A careful external examination of the uterus will be made, and external measurements taken. If there are any indications for it an internal examination will be proposed and the internal conjugate noted. Whatever the result of the examination, the first duty of the doctor will be to advise as to personal hygiene. Not only must she inculcate the practice of healthy habits but counteract the effect of popular prejudices. Clothing, food, fresh air and exercise will all require consideration. The most common popular mistakes made are to advise overfeeding and discourage exertion. Working women must be warned against the danger of certain kinds of excessive straining in their housework, especially at their menstrual epochs, but even the artisan classes are now in danger of going to the opposite and worse extreme of resting too much. Another popular and professional prejudice exists against having any dental treatment carried out during pregnancy. It is most important that any woman with decayed teeth should be referred to the dentist.

Regulation of the bowels must be insisted on, and the general rule laid down that what is healthy generally is healthy during pregnancy, but that whatever is generally unhealthy or risky at other times is far more prejudicial while enceinte.

The general rule as to treatment is involved in the definition of the object of an ante-natal clinic by the Ministry of Health already quoted. Advice and prevention is the primary object of the clinic, but of neces-

sity some minor forms of treatment must be carried out or prescribed for. Thus if constipation exists the suitable measures must be advised. If any malposition is discovered on examination it should at once be rectified and an appropriate pessary inserted or other treatment be prescribed. But if any continued medical attendance is requisite, or any serious condition discovered, the patient should be referred either to a private practitioner or to the obstetric department of a hospital. The midwife, if co-operating, should be asked to suggest a doctor in case the patient has no regular attendant and no special preference.

It is important that patients should attend at regular intervals until their confinement, say every month for those who are going on satisfactorily ; those requiring any treatment or special care would attend every week or as often as is requisite.

If venereal disease is discovered or suspected, the case should be referred for diagnosis, and, if necessary, treatment, to the nearest venereal disease clinic.

A certain number of women will be found to be in such a dangerous state of health or to have such deformity or abnormal conditions of the pelvis as to make it very desirable that they should not be confined at home, but where they would have every facility for skilled nursing and attendance by an experienced obstetrician. For such it is important that there should be an arrangement with some lying-in hospital which will secure admission for any case requiring it.

(2) Health Visitor's Duties.

Superintendence of the Clinic.—The superintendence of the infant welfare centre should be one of the most important parts of the health visitor's work. It provides scope for ability of all kinds, and the perfect maternity centre cannot exist without a superintendent who combines a great variety of natural gifts with a well-stored mind. The greater number

of maternity centres are still managed by voluntary societies, many of whom employ their own superintendents, in which case the health visitor is not held responsible for the management and instruction given at the centre; but a number of municipalities have their own clinics or schools for mothers or infant welfare centres, as they are variously called, and here the health visitor has more scope and has a very much easier task. The value of voluntary workers in starting, organising and finding the funds for the first schools for mothers can hardly be over estimated. I owe a deep debt of gratitude to many voluntary workers for their patient, and in many cases skilled assistance; but the time has now come for all centres, in towns at any rate, to be municipalized, and voluntary help should only be allowed in these centres directly under the supervision of the health authority. The best kind of helper for this purpose is the pupil who intends to become a public health worker, or someone who is willing to work under orders, or who will undertake some definite duty, such as minding babies while their mothers are at a class, or giving instruction in knitting or cutting out garments.

At a municipal clinic the health visitor's duties are multifarious. She has first of all to provide the congregation by asking the mothers to come when she visits them in their homes. A popular health visitor has no difficulty in crowding her clinics. Her difficulties come later on!

Clinics may be held in rooms borrowed or hired for the occasion, or they may belong to the municipality; the latter is preferable, and the rooms should be large and well furnished and clean. There are so many well furnished baby centres now existent that the reader is advised to visit one or more of them on the first occasion. Nearly all instruction on the subject as given in articles, lectures, &c., tends to lay too much stress on furniture and outward trappings, too little on the atmosphere. You can have the most ornate and elaborate

fittings, equal to an up to date hospital, but if the mothers are treated to the business-like but inexpansive atmosphere of an average "out-patients'" department at a crowded hospital, they will not get as much benefit as from a shabby old room with the minimum of fittings, where the health visitor is at once hostess and teacher and makes the mothers feel welcome and at ease, and at the same time keen to learn. The clinic afternoon or morning should be arranged at the time best suited for the mothers. Two-thirty is a very popular time, as it enables the mother to get back in time to meet older children returning from school.

Daily Routine.

The health visitor, then, has to arrive by 2 p.m., and to see that everything is in order in all the rooms, particularly the doctor's room. She should get the mothers to undress the babies a few at a time, so as not to wait long for weighing, and weigh them, taking the opportunity while each baby is brought to her of saying a few words to the mother. She must keep an attendance register, as well as fill in a weight card for each child, and she should have at least two competent helpers (where there are no other health visitors) to copy the weights from the cards on to sheets for the doctor, weigh out the medicines, &c. Incredible things are being done single-handed by health visitors, such as performing all the duties just enumerated, besides going into the doctor's room occasionally to take special instructions about an infant, and generally seeing to all the mothers' wants for as many as thirty to forty mothers in an afternoon. But such work is terribly exhausting, and it is impossible to give the mothers all the necessary attention under such conditions. The health visitor should aim at getting a second clinic if the average attendance rises to much beyond thirty for an afternoon, and should insist upon regular assistance as I have mentioned. A properly run clinic should aim at the following ideals :—

Ideals.

(1) See that each mother gets sufficient time with the doctor, if not every week then in regular rotation as often as necessary. Avoid keeping the mothers waiting too long. If the doctor is unavoidably late, then see each infant yourself and dismiss those whose progress has been satisfactory since the last visit. If, as does occasionally happen, the doctor is prevented from coming altogether; the health visitor must advise to the best of her ability, repeat such simple remedies as has been ordered by the doctor the week before, such as virol, grey powders, &c. (usually the doctor instructs the health visitor what she is to give out in his or her absence), and recommend medical treatment for any case that seems to require it. This is very responsible work, but every health visitor of many years' standing has had to do this frequently.

(2) Keep the ball of instruction rolling chiefly by pleasant conversation. This is a great art, but it is necessary, particularly with new comers, in order to arouse their interest and stimulate them to attend the classes.

(3) Give special instruction to those who have been seen by the doctor and ordered any change of diet, &c., and always make an appointment for a visit in order to follow up the directions given at the centre.

(4) Greet all the mothers on arrival and departure.

(5) Stop the use of comforters.

(6) See that the children are made to observe clean habits while on the premises.

(7) Keep the temperature, lighting and ventilation adequate.

(8) Be often in the passage to see that there is not a blockage of perambulators, &c.

(9) Distribute papers and various literature, such as "the specimen dinners for a child of 18 months," "how to make barley water," &c.

(10) When there are slack times, and these always occur on wet days, take the opportunity and tell the mothers

interesting things or open informal discussions on houses, crêches, or any other absorbing subject. The health visitor will learn a great deal from mothers, even if they do not learn much from her. There are certain pitfalls in running clinics which should be avoided.

Pitfalls.

(1) *Over-organization.*—This is a fault very often met with in voluntary centres, less often in municipal centres. The writer has been shown over centres where the homely atmosphere is absolutely lacking, where rules were made (and constantly changed) about every trivial point, and consequently a great deal of energy deflected into explaining rules to new comers. As far as possible, rules should be eliminated, e.g., it is no use saying "no gossipping allowed." If the mothers are kept thoroughly interested, gossipping is reduced to a minimum by natural means. I remember one zealous young doctor who asked the committee to make a rule that :—"any mother who was insubordinate or refused to obey his ruling should be requested to retire from the centre." I am happy to say that no such contingency ever occurred! The object of the clinic should be that every mother present should receive the maximum amount of instruction, encouragement and pleasure from the afternoon compatible with the time at the disposal of the health visitor and her staff.

This can obviously not be achieved if the workers discuss their private affairs with each other, or as I have frequently seen done, break into the conversation of the health visitor with a mother. There is a class of worker (I am happy to say that it is not found at all centres) who by lack of manners in this respect shows up very unfavourably beside the mothers themselves (who usually have excellent manners). The health visitor, however hard she may find it, must always avoid showing that she is "rattled." The successful conduct of a popular clinic involves a considerable amount of mental and physical strain. If a person has not a good memory and a quick

wit and an equable temperament she will never be well fitted for the job.

(2) *Wasting Opportunities for Instruction.*—It is fatally easy when clinics become too large to rest upon the props of well arranged weighing rooms and furniture, and the doctor's instructions, and the dispensation of tea, and to let it go at that; but that is not enough. It is only by constant talk round about the subject of babies, that one "gets in" instruction and arouses interest in the classes amongst the mothers. For this reason, it is very important, that voluntary unskilled helpers should be subordinate to the trained helper at clinics.

(3) *Unnecessary Interruptions.*—I have no use for the supervising voluntary worker, she is far more often a hindrance than a help. If a voluntary helper will take charge of a tea room and confine her conversation to general matters she may be only helpful; too often she interrupts the health visitor and makes her work more difficult. Can anyone imagine a school teacher, while demonstrating a point to children (and without the added difficulty of crying babies), tolerating constant interruptions by having the door thrown open and someone showing in visitors who talk loudly while in the room and effectually prevent any instruction during their visit? An occasional visitor who sits and looks on silently is quite another thing and should be welcomed. Any middle class woman who will do so should be encouraged to attend as one of the mothers. If she feels any diffidence in accepting the services gratis she can give a present of baby clothes or money towards any special fund. The sooner the public get over the idea that there is anything derogatory in attending a welfare centre, the better. The middle class mother is often not in such a good position for learning how to manage young children as the mothers attending a centre; she often has to contend with ignorant, ill-trained nursemaids, and there are still private doctors and expensive nurses who are not sound on the subject of

natural feeding. The health visitor may not all at once be able to achieve her own way on all these points, but at least she should know what is the ideal to aim at in starting and carrying on a school for mothers.

Premises.

As to premises, although any large room simply furnished can be made to do for a time; a minimum of three rooms on ground floor level, one for a waiting and tea room, one for a weighing room, and one for a doctor's room should be ultimately procured. The rooms should be distempered and have parquet or linoleum covered floors, cane-seated chairs, with a few special nursing chairs to undress babies in, and enamel basins for the clothing (wire receptacles answer the same purpose). The best means for warming is a coal stove, or a gas stove if the room is small, and it is exceedingly important that the undressing room should be warm as well as well-ventilated. Over-crowded ill-ventilated rooms are very likely to give the babies cold; and this is quite the most serious drawback that a centre can have, and often prevents mothers bringing their children again if they contract a cold from being brought the first time. The doctor should work in close collaboration with the health visitor, who should take every opportunity of making herself conversant with his methods. The health visitor has sometimes a good deal of influence in the appointment of the doctor. The medical work is arduous and not particularly well paid, so that few doctors undertake it unless they are thoroughly interested in the question; but doctors vary, and it is the business of the health visitor to notice whether the doctor's services are appreciated, and in cases where they are not—and sometimes these services are undertaken by quite unsuitable people—it may be desirable to point this out to the medical officer of health in order that he may recommend the committee to appoint someone else before the work of the centre seriously suffers. London is particularly well off in this respect; there are many keen

up-to-date doctors undertaking clinics at infant welfare centres who are delightful to work with in every way; but in those cases where the doctor is unsatisfactory, it might be better to have no clinic at all rather than run a bad one, and the medical officer of health should be consulted.

Scales.

The scales should be of a kind easy to handle; there are various sorts on the market; the lever ones are very good for the purpose, and the basket should contain a blanket well protected by waterproof paper or sheeting, and for each child there should be a fresh sheet of tissue paper spread over the sheeting. Sometimes a voluntary worker will do the weighing admirably, but on the whole it is best left to an expert handler of babes, as it is thus performed with the minimum effort and upset to the baby. Immediately the weighing is over, the health visitor should see that the napkins are replaced and the baby either dressed or wrapped up sufficiently until the doctor is ready to see it. If this is carefully carried out, there is much less chance of dirty floors and of the baby catching cold. A small chamber should be kept in each room and the mothers constantly encouraged to hold out the children. Neglect of details like this may greatly inhibit the educational value of the centre.

The question of *records* is a very important one. It is essential to have accurate records kept, but it is still more essential to keep the clerical side of the work subordinate to the human, and teaching and social side. The health visitor will find that if she cultivates her memory it will be a very valuable asset. There is nothing more gratifying to a mother than to have her history and circumstances remembered by the health visitor, few things more annoying than being constantly asked the same questions. The ideal health visitor should keep accurate and neat registers and sheets (see Appendix V (*b*)) of all cases attending the centre, and should also know every mother again, and all about her, after seeing and talking to her once or at

most twice. If a new mother previously unknown to the health visitor comes to the centre for the first time, it is especially necessary to "go easy" in the matter of asking questions. It is often better to leave for another time some unfilled columns rather than punctiliously ask the formidable list—that even the smallest form of sheets seem inevitably to require—at the risk of the mother never coming again. If a clinic shows a large proportion of defaulters after one visit, it is often due to this cause. This is a mistake often made by novices, but should be easily avoided, if it be always remembered that records are in themselves of no value whatever.

Visiting Centre Cases.

It is extremely important to visit all cases as soon as possible after their first visit to the centre. When a home is found to be a happy, well kept one, after the first time only occasional visits need be paid; in some cases no visit at all is necessary unless some special reason occurs. If a mother is absent from the centre when she was expected to be present, it is better to visit and ascertain the reason. If a baby is delicate and artificially fed, especially if it is not thriving, the health visitor should visit as often as possible. For one thing, there is no other way of knowing whether the instructions given at the centre are being carried out. The writer remembers a case of delicate twins attending a children's hospital as out-patients, who had been fed on Nestlé's milk, and who were ordered a change of diet to dairy milk. The mother tried the change, but had such a bad night that she reverted again to Nestlé's, and brought the children back to the hospital a week later. The children were weighed, and found each to have gained half a pound. When the mother's turn came to see the doctor, she was just going to tell him the circumstances, when he exclaimed upon the improvement in the twins' health, and pointed the moral of the superiority of dairy milk to his students, so that the mother "hadn't the nerve" to tell

him of his mistake, and continued to attend the hospital for some weeks until discharged, without ever divulging the fact of her persistence in the old diet! She got them on to dairy milk later at my instigation, and they did very well. Now this particular deception has often been practised in the writer's experience, partly because some doctors under-estimate the difficulty of changing an infant's diet, but more often because some mothers are too "slap-dash" in their methods to carry out instructions efficiently, and it is just here that the health visitor's patient assistance is most valuable.

Another reason for visiting homes, sometimes even when everything seems all right, is that often the mothers will not speak in front of others of some condition that has arisen, and which is affecting their health or pockets, whereas they are only too glad to confide in the health visitor in their own home.

Model Garments.

Every centre should exhibit a certain number of model garments, and it is a very good plan to buy wool wholesale and sell it at cost price to any mothers who care to knit their children garments. Type-written directions can easily be distributed for those who have time and ability to knit. In addition to this, it is a good plan for the health visitor to visit the head teacher of some elementary school near the centre, and provide the wool and patterns and get her to let the girls knit garments, such as vests, binders, leggings, &c. The writer has met with unvarying courtesy and the greatest assistance from many head teachers in this respect, and the children are delighted to knit a real vest for a real baby. If a voluntary worker can be induced occasionally to get up a jumble sale, provided that it is kept till the end of the afternoon and no improperly made baby clothes are accepted for it, it will be a real help to the mothers, and the proceeds may go towards tea parties or treats, or a boot fund, or anything else that the mothers would like.

Milk Grants.

Now that milk grants to practically every poor mother are in vogue, a great deal of extra work and responsibility has been thrown upon the health visitor. She is often required not only to make out orders for every mother receiving milk grants but also to check the bills. This is a very bad arrangement, and the constant practice of imposing additional duties involving fresh responsibilities and anxieties on the health visitor, *of course* without extra remuneration, is becoming a very serious matter. Arrangements should be made with the accountants' department to pay and check all bills; and the health visitor should confine herself strictly to giving out the order and notifying its cessation to the accountant. Most medical officers of health would agree with this policy. Many do not like any part of their work to pass out of their own department. The appointment of child welfare clerks would obviate this difficulty.

Classes.

When a maternity centre has been inaugurated sufficiently long to have a large regular attendance at the clinic, it is time to start classes of instruction. The best kind to begin with is a needlework class with a short lecture from fifteen to twenty minutes given during the afternoon. The needlework class may be of various kinds, sometimes it is merely an opportunity for the mothers to examine patterns of children's clothes at their leisure, and buy by weekly instalments flannel and other materials that the health visitor has been enabled to obtain cheaply wholesale. Then a few patterns can be cut out, and those mothers who care to may bring crochet or knitting and do it during the afternoon. If instruction is given in any form of needlework it is almost essential that all the mothers should do the same garment, as otherwise the health visitor will be unable to cope with any number. The writer conducted a class of sixteen or so for some months, all of whom learned to knit babies socks. They

could none of them do this when the class started, and quite a number of them successfully completed pairs of socks, some of them becoming experts before the end of the time. This enabled the knitting to be continued during the short lecture.

It is very desirable that there should be some form of yearly or half-yearly *exhibition of work* so that the mothers have some aim for their work and something to look forward to. Many councils possess one or more members willing to give teas and come and view the work on occasions of this sort, and it is highly desirable to get the councillors interested in the centre by some such means. Often most generous presents are made by councillors, such as a sewing machine for the use of the mothers, or children's clothing, which can be given away to necessitous cases or sold cheaply. Quite the best incentive to classes at present is the yearly competition among all the schools for mothers affiliated to the National Association of Infant Welfare Centres, 4, Tavistock Square. This gives all sorts of chances to skilful mothers, and is a very good means of drawing in the clever ones and exercising their ingenuity, which in turn helps to teach the duller ones. But, in saying this, let me point out that a serious risk exists of drawing on the clever and ignoring the stupid ; particularly is this a temptation to a good teacher, who naturally gets carried away by the interest of the intelligent, and is inclined to forget the dullards. The ideal is to provide sustenance for all (allowing that some women are apparently quite unteachable), by recapitulating broad facts till everybody in the class can answer questions about them, and by explaining further and giving more details for the benefit of the inquiring. There are few more delightful duties to one who knows how to teach, than taking a class of bright young mothers ; and the yearly examination paper in the annual competition arouses the greatest excitement and amusement. One mother known to the writer even went to the British Museum reading room to read up some point on infant

welfare. Another wrote an excellent essay, which was adjudged as the best in all the competing centres, and was published in *National Health*. Having selected the subjects for the syllabus for the quarter or year, the health visitor should arrange her facts as graphically as possible and avoid the use of, as far as possible, long or difficult words. In fact, if she is to succeed she must be a much better teacher than many lecturers employed at colleges and other places of instruction at a guinea an hour! I think very few councillors realize in the least that their health visitor is primarily a teacher. It would be greatly to the advantage of the medical officer of health and health visitor, if several persons interested in and qualified as authorities on education were to serve on the Maternity and Child Welfare Committee. It is deplorable that no qualifications whatever are required of councillors, and that so often the good experience of one or two members of the committee is nullified by the stupidity or apathy of the others.

The health visitor, then, must try and acquaint herself with the methods of good teaching if she has had no previous experience. I have known two lecturers at infant welfare centres who were born lecturers, i.e., they possessed the art of presenting their facts lucidly and holding the attention of their audience, whose value as teachers was greatly diminished by their lack of education; they made constant ignorant mistakes and were not to be trusted to answer the questions of their classes correctly. The well educated person finds it so easy to say, when she does not exactly know the answer, "I am not sure of that point but will look it up," and will only gain the respect of the class. The ill-educated are so inclined to think they know, and give wrong answers. Besides holding ordinary classes, for which the mothers should be required to do occasional home work (a source of great interest to themselves and frequently to their husbands, and also of a considerable amount of innocent merriment!), the health visitor should sometimes get

outsiders to come and talk on various subjects. The chief subjects chosen should be the care of infants, their education, diet and its relation to health, general hygiene, simple first aid, and home nursing, &c. Occasional cooking demonstrations are much appreciated. The health visitor should show models and diagrams in order to make the subject more interesting and easier for the mothers to understand. If diagrams are customarily hung up on the walls of the centre rooms they should be changed from time to time. While the class is going on whenever possible, the babies and toddlers should be minded in another room to give the mothers a chance. A folding up pen is very useful for the purpose, and councillors and other friends should be asked to give gifts of suitable toys from time to time. The mothers themselves should always be consulted about the management of their centre, selection of classes, &c., and this is one great reason why it is more desirable to have a municipal than a voluntary centre ; the former enables the mothers to feel that the centre belongs to them and that by paying their rates in some instances directly, in others indirectly through their rents, they are contributing towards its upkeep.

It is quite wonderful how by the force of collective opinion at a well conducted clinic, mothers will learn to change their habits. Take the case of the hard binder. It is only very rarely that mothers attending a school for mothers put up a fight for continuing the use of this extraordinary garment ; whereas for years prior to the establishment of a centre, the writer in vain grappled with the mothers in their homes. If a mother unconvinced by any advice argues the point, the other mothers invariably stand up for the health visitor, supplementing their remarks by witnessing to their own infants' progress. The use of the comforter is quite the worst habit and the hardest to cure of any that the health visitor has to combat, but even here she has a very good chance with mothers of first children. As regards *expectant mothers*,

they should be encouraged to come to the classes and prepare with the assistance of the health visitor all their infants' clothing. This is especially valuable to the mothers of first infants. Now that infant welfare centres are so popular, an increasing number of mothers get to hear of them through their friends, and wherever a voluntary system of notification of pregnancy occurs through arrangement between the hospitals and midwifery associations and the medical officer of health, it is possible to visit the mothers and invite them to come and "try" a class at the centre. It is unfortunate that the public conscience is so dead on the subject of garments for "poor" people. So many odious unhygienic children's garments are given away or sold cheap at missions and other places. Very often good material is ruined by the ignorance of those preparing the clothes. At one time the writer set her class to alter a consignment of low-necked short-sleeved vests into suitable garments by the addition of woollen sleeves and yokes sewn in, but a great many sent out are absolutely useless.

Other Activities.

There are many other activities connected with centres, and the health visitor should keep her eyes open and be ready to take up any idea that will interest the mothers and not be too difficult to carry out. Occasional teas and outings are a great asset and councillors are often willing to pay for these. As a rule voluntary centres get more in this way owing to personal susceptibilities of councillors, but there are ways of getting over this difficulty which every health visitor must discover for herself. It is advisable also if any exhibition of "Ideal Homes," or other interesting show comes into the neighbourhood to get free tickets and take some of the mothers. Often friends will come and bring flowers for the mothers or to decorate the centre. Old infant clothes of good pattern are very valuable and the writer always made a point of getting her friends to send on their infants' out-grown garments, a fact much appreciated by the mothers.

A health visitor should keep the balance between being too easy going and too didactic. She must be dogmatic, because that is the only way to get your points home with the unlearned. The best method for her to adopt when she finds that a mother refuses to follow some piece of advice, is to enter into collusion with the doctor and see that the point is rubbed in by him or her independently. In any case, any advice given in public to a mother must be tendered very courteously; sharp speaking is of no use at all, but on essentials the health visitor must be absolutely firm and in the end the mother invariably gives way unless she came under an erroneous impression that she was going to be given things, in which case she does not come again.

Statistics.

Now a word as to *statistics about attendances* at infant welfare centres. Reports are often issued which are valueless, because they do not discriminate in their records of attendance between those mothers who attend regularly, and those who merely come once out of curiosity. All records should show clearly what percentage of mothers attend regularly for a reasonable time period.

CHAPTER VI.

INFECTIOUS DISEASES.

THE health visitor is expected to visit houses where certain infectious diseases are notified or known to exist. These are mostly those which are not removed to hospital for isolation purposes. Scarlet fever, diphtheria, small-pox, and enteric fever, are usually taken to a fever hospital as soon as they are notified, and the necessary steps are taken and warnings given by a district inspector. The diseases for which the health visitor is most useful are those in which the infection is not easily carried, those which are often regarded by mothers as of slight account owing to their wide prevalence, and those in which the practical advice of a trained and experienced woman may greatly increase the chances of recovery and diminish the spread of infection. The following brief account of some of these diseases is not intended to replace the works which the visitor must read and consult, but to point out the special facts which she should have at her fingers' ends.

These diseases are measles, whooping cough, diarrhœa, tuberculosis, influenza, ophthalmia neonatorum, and puerperal fever. It is important that the visitor should have special knowledge of the preventive and hygienic treatment of these common infections. Generally it will be her duty to advise that medical treatment be obtained and the doctor's orders carried out, to obtain such separation of the patient as is practicable, to indicate how ventilation or open-air treatment can be best secured and to advise as to cleanliness of patient and sick-room, and diet of the patient. When a district nurse is available

the mother should be pressed to obtain her services in acute cases, and the health visitor may then retire. In some rural districts the health visitor may be expected to combine the duties of district nursing with her own, and the same may be true in the emergeney of an influenza or other epidemic.

The special points for the health visitor to bear in mind with respect to each of the above diseases will now be noted.

Measles.

This disease is most fatal between 6 months and 2 years, and usually benign after 5 years. Infants under 6 months are rarely infected, and when they do suffer the course of the illness is very mild. Between 6 and 12 months, on the other hand, the disease is very fatal, and continues to have a high mortality up to 2 years, but from that age the fatality rapidly diminishes.

It is not the business of the health visitor to make a diagnosis, but she should know well the symptoms of this and similar diseases, so that she can form an opinion as to whether the mother's suspicions are correct, whether to advise calling a doctor, and what report to make to the medical officer of health. In measles after a few days of catarrh, cough, and running at the nose and eyes, a rash appears about the fourth day, first on the face and behind the ears, and spreads to the trunk and limbs. The spots take on a blotchy crescent-shaped arrangement, quite different to the uniform arrangement of scarlet fever spots; scarlet fever too, nearly always begins on the neck and chest, and there is sore throat, but no cough. The chief complications of measles are bronchitis, pneumonia, diarrhœa, and inflammations of the ear and eye.

It is one of the most infectious diseases at the beginning, and any unprotected child in close association with the patient is almost sure to have contracted the infection before the rash comes out. But the infection is

short lived and not easily carried, and has probably passed off within three weeks at the latest.

The objects of preventive treatment are : (1) to secure that no young unprotected child shall be exposed. No children from other houses must be allowed to come in.

(2) To promote recovery by rest in bed, warmth, cleanliness, fresh air and regulated diet. Strict isolation in the home is seldom practicable, but in the interest of the patient it is important that he should have, if not a separate room, in any case a separate bed, where he must stay till rash, catarrh, and all signs of illness have passed away. It is safe to advise a week in bed for the mildest case, and a fortnight upstairs. As much light and air as possible are desirable. It is for the visitor to show the mother how these are to be secured without an unpleasant draught, or undue exposure of the eyes. By simple means (as the use of a screen) it is nearly always possible to flood the room with air, and at the same time to protect the patient from chill and glare.

A fire is useful to help ventilation when the windows cannot be widely opened, but it is most important that the room be not kept too warm, and the child not covered with a heap of bed clothes as well as several body garments. A steam kettle should not be used unless specially ordered by the doctor.

Cleanliness of the room, the bed and the patient, are of great importance. The mother should be warned to use damp dusters and not raise a dust by sweeping with dry and naked brooms.

The amount of washing which is safe and desirable for the patient will depend largely on the intelligence of the mother, but daily changing of night dress (including of course under vest, if worn) is most important. Cleanliness of the mouth may prevent ear disease and other complications. It may be secured by frequent cleansing with boric acid in warm water, and by such diet as dry toast, oranges and bananas. There is no need to keep to slops and soft pappy food, but of course all rich and indigestible articles must be tabooed.

The care of the eyes is most important, but light is not necessarily injurious. When there is any discharge they should be frequently cleansed by warm water and boracic acid. The child should lie so that his back is turned to the window when he sits up.

Although the visitor must generally recommend calling the doctor in in all cases, she should know what are the dangerous symptoms which make this particularly important.

Dusky lips, quick breathing, nostrils working, continuous short cough, swelling and discharge from eyelids, earache or running from the ear, and diarrhœa, are urgent indications for medical treatment and skilled nursing.

In London and some other places a few measles cases are taken to the isolation hospital where home conditions render this essential.

While in bed warn against excessive heat of room and bed; on getting up counsel warm clothing and avoidance of chills.

Consumption frequently follows measles, and parents should be warned to be on the watch for any weakness following recovery and have the child medically examined. This can be made a reason for recommending regular attendances at the Infant Consultation. Some sanitary authorities disinfect rooms, bedding and clothes, after measles as after scarlet fever. Others are satisfied with directing the mothers to apply simple fresh air and soap and water disinfection, e.g., allow fresh air to blow through the room for several hours, wash in boiling water body and bed linen, air the blankets in sunshine or wash them, wash floors, wood work and furniture with soap and water. If the visitor has been in the sick room she should wash her hands before leaving; after visiting a case of measles she should avoid coming into direct contact with other children as long as possible.

The medical officer of health will probably have printed instructions for the mothers. A copy of these

will be left at the house after first explaining them and emphasizing their importance.

Before leaving the visitor should inquire for overlooked cases. These may sometimes be found running about the street, or sitting listlessly indoors. It is very probable that many cases of measles occur in which either no rash appears, or a rash so slight as to be overlooked. Such cases though commonly slight may have serious complications such as broncho-pneumonia or diarrhœa. Any child, therefore, with a bad cold, in or adjoining a measles infected house, should be treated as a measles case and kept in bed.

The health visitor should acquaint herself with the local regulations as to exclusion from school on account of infectious disease, so that she can advise the mother accordingly.

German measles is not measles at all, but a very mild but infectious disorder, common in older children and rarely, if ever, fatal. It is characterized by slight fever, and a rash whose appearance is intermediate between that of measles and the scarlet fever eruption. It is generally easily recognized by the swelling and tenderness of the glands at the back of the neck. It is chiefly important as interfering with school attendance.

In view of the possibility of a mistake in diagnosis, it is usually made subject to the same regulations as measles.

The repetition of visits to *measles* cases will depend on circumstances, but in any case provided there are uninfected children in the house, another call should be made in a week or ten days to inquire for secondary cases. These commence from ten to fourteen days after the beginning of the first case.

Whooping Cough.

Although less fatal than measles, whooping cough owing to its greater frequency, causes as many deaths as diphtheria and many more than scarlet fever.

Like measles it is very fatal under the age of two years, less so but still fatal under five, and usually benign after that age. Everything possible should therefore be done to protect children under five from exposure to infection when whooping cough is prevailing.

Unfortunately it is even more difficult to diagnose than measles. Of course there is no difficulty when the whoop is well marked, but this is seldom the case for at least a week after the affection begins, and often no whoop appears throughout the whole course of the illness.

It begins with a catarrh in which the cough gradually becomes the prominent feature. As the cough gets worse it tends to come in fits which are most frequent at night. The fit consists of a rapid series of short coughs which are expulsive efforts to drive phlegm from the bronchial passages. These are followed by the whoop which consists of a quick deep drawn inspiration combined with some spasm of the glottis, which accompanies nature's effort to refill the lungs. Although it is primarily a disease of the air passages, there is about it a marked nervous element probably due to a poison generated by the infection, which by acting on the nervous system produces the characteristic fits and other nervous symptoms of the affection.

The treatment of the early catarrh stage is similar to that of measles, rest in bed, light diet and plenty of air. On getting up it is important to guard against chills by warm but light clothing, to support strength by nourishing but easily digestible diet, and to strengthen the nervous system; this is best done by an open-air life combined with freedom from exciting and disturbing influences. It will be easily seen in how much better a position the rich are than the poor to carry out the proper care of a case of whooping cough, and one can understand why the fatality is so much greater among the poor and why the mortality in England and Wales has steadily fallen in the last forty years with the rise in the standard of living.

The mother must be pressed to obtain medical advice and treatment whenever infants under two years are attacked, when the paroxysms of cough are very frequent, when the breath is short, and the nostrils work, and when the child goes off his food.

If vomiting after cough occurs repeatedly food must be given frequently in small quantities; milk may be given just after a fit of coughing.

The duration of the infection is not known owing to the microbe not having been discovered. At various times and by various authorities it has been given as lasting from three weeks to six months. Probably both extremes are correct, and as with diphtheria and enteric fever, while in most cases the infection has but a short duration, in a few it lasts for very prolonged periods. The later cough is mainly a nervous symptom and not a necessary indication of infectiousness, but as long as it is accompanied by bronchial secretion (phlegm) the case should be regarded as infectious.

The task of the adviser to a mother in a town cottage is difficult, she has to steer between the Scylla of exposure and the Charybdis of close rooms. She has to recommend an out-door life combined with abundant rest and without exposing others to infection, and to advocate feeding up while carefully avoiding indigestible articles and over-loading the stomach. For a month after commencement she will seldom be wrong when she advises a few days' rest in bed, with windows opened to the fullest extent possible, and no obstruction from curtains and blinds. Plenty of milk, milk pudding, bread and dry toast with butter or margarine, fresh white fish such as herrings freed from all bone, a little mashed potatoes, oranges and bananas make a safe diet, and some cod liver oil may be added in later stages. The amount of quarantine will depend on local school regulations.

Consumption and other constitutional taints may follow whooping cough and as with measles the mother should be urged to have the child regularly inspected by a

medical man for at least a year after convalescence. If a private doctor is impracticable she should bring the child to the infant consultation.

DIARRHŒA.

By diarrhœa we here mean the infectious disease which specially affects children in the summer and autumn months and is called by various names such as summer diarrhœa, enteritis, zymotic enteritis, infantile diarrhœa, cholera infantum, &c.

The exact cause of the infection is unknown, nor is it certain that there is any one specific germ of the disease. But there is no doubt that some poisonous materies morbi exists in the stools of the patients and that the disease is conveyed from one child to another in the home through dirty conditions, and also carried by impure milk and other food. Flies may convey it several hundred yards, and probably in dry weather it may be carried in the wind by dust. The disease rarely occurs in children nursed at the breast, in strictly clean homes, and where all food is rigidly protected from flies.

The summer prevalence commences in July, reaches a maximum at the end of August or beginning of September and then gradually diminishes and disappears in November. The severity of the annual epidemic depends chiefly on the amount of continuous hot weather experienced. Isolated cases are however liable to occur all through the year. Adults often suffer from summer diarrhœa but it is usually slight in them, although old persons occasionally die of it.

The hot weather probably acts in three ways (1) by directly favouring the multiplication of the infecting material; (2) by reducing the vital resistance; (3) by causing an increase of flies and making them more active. The last is perhaps the most important.

From what has been said it follows that the objects to aim at are (1) breast feeding in place of bottle feeding; (2) that all milk should be boiled or sterilized, and then

carefully protected from contamination until it is used ; (3) absolute cleanliness of house and person ; (4) abolition of flies.

Unfortunately summer diarrhœa is not generally notifiable, though notification has been the practice in Woolwich for many years and has resulted in a great diminution of the disease. A few boroughs have recently followed suit. But by means of infant consultations mothers may be induced to send word to the Town Hall when one of their children sickens with diarrhœa.

On the occurrence of a case prompt action is desirable. The doctor should be sent for but without waiting for his arrival the mother should be told to discontinue milk and other food for at least twenty-four hours and to give nothing but albumen water, rice water or barley water. Milk (except breast milk) is generally undesirable throughout the illness. One small dose of castor oil should also be given ; this both clears away irritant matter from the bowel and has a soothing action on the mucous membrane.

The mother must be warned as to the highly infectious nature of the excreta and instructed as to disinfecting and disposing of these. Soiled napkins and clothes should at once be soaked in water containing a disinfectant and left there till they are washed. The mother should be particularly careful to wash her hands after changing or attending to the child, and before preparing a bottle or any food. This direction is of the greatest importance and should be specially emphasized. It is probable that diarrhæa is often conveyed from an older member of the family to the baby, and spread through the house by the dirty hands of the mother, exactly as enteric fever commonly goes through a family when the same person nurses the first patient and prepares the food for the other inmates.

A case of diarrhœa gives a health visitor a good opportunity of insisting on the sanitation of the home, and pointing out how dirty floors and walls, crumbs on tables, beds, &c., and food not put away in larder or

cupboard attract flies. She should show the mother the breeding place of flies in house refuse and rubbish left to accumulate in the yard. She should take note of any manure or filth collections in the neighbourhood and report the same to the medical officer of health.

She should inquire for any diarrhœa cases among neighbours and will in all probability find some close by.

Tuberculosis.

Tuberculosis nurses or visitors are frequently provided by sanitary authorities and tuberculosis dispensaries, and the ordinary health visitor is often expected to visit notified cases of the disease. The following are the most important points about it that the visitor should keep in mind.

Pulmonary tuberculosis is a decidedly infectious disease, but at the same time one in which the *infection* is easily prevented, and in which for certain reasons the infectiousness may and should be considered of little account after the proper steps have been taken. In scarlet fever, small-pox, &c., a very slight amount of infection is enough to cause a serious attack of the disease. But in tuberculosis everything depends on the dose of infection, the duration of exposure and the amount of dilution. It is probable that every person who has lived several years in a town has already been infected to some slight extent, and it is a well known fact that nurses and doctors at consumptive hospitals carry on their duties with impunity, and without being more liable to the disease, perhaps less so than persons not so exposed. It follows that where open-air treatment is carried out, the patient instructed to cough and expectorate in a proper manner, and the sputum properly disposed of and the rooms kept clean without raising dust there should be no fear of infection. Young children are, however, very susceptible to tubercle bacilli, and should as far as possible not be allowed to live in the same rooms as a person with

"open" tuberculosis, i.e., with a consumptive who expectorates.

Much more important than guarding against the inroad of tubercle bacilli is the *increasing of the natural resistance* of the body so that the invading germs become harmless. This is done by all the means which generally promote health, such as free movement of air, a liberal supply of nourishing food, cleanliness of person, sufficient and suitable clothing, cheerful occupation of mind, and full exercise of the muscles, preferably by useful work, combined with sufficient rest.

As regards movement of air and clothing it must be remembered that cold stimulates the circulation and improves appetite and digestion, so that the aim should be to keep the body as cool as is consistent with comfort. The air in rooms should be kept moving at a moderate rate, to promote the action of the skin. This means attention to the strength and direction of the wind and graduating the openings of doors and windows accordingly. In cold weather the opening should be small on the side of the room from which the wind blows, and large on the opposite side.

A fire or gas stove with flue into an open chimney always means a certain amount of movement of air in the room. When a gas stove is used care must be taken to see that it is properly connected to the chimney and that the chimney is in working order. When this is the case a gas fire is preferable to a coal fire. Rooms are very liable to get too warm and close in the evening when the family sit round the fire.

Clothing should be as light as possible but warm enough to prevent discomfort. A frequent change and cleanliness of under-clothing must be insisted on. The same under-clothing should never be worn night and day.

A warm bath should be taken at least once a week and the body sponged and rubbed over with a rough towel daily.

The doctor will prescribe what work and exercise are desirable. Generally speaking, patients whose temperature rises daily above 100° F., are kept in bed. All others not at work should take as much walking, or other exercise as they can manage without undue fatigue or rise of temperature. But the visitor will not often require to advise exercise. Much more often she will meet with men who are going to work with temperatures far above normal, and will have to insist on rest and medical treatment.

Cheerfulness of mind is most important but it is not to be obtained by deceiving the patient as to his condition and hiding the fact of his disease from him. Friends must be made to understand that the hope of recovery depends largely on the patient knowing what he is suffering from, and being an intelligent co-operator in the hygienic and other remedies prescribed. Only in cases of hopelessly advanced disease is it excusable to hide the truth as to the presence of consumption.

Long rest in bed at night and rest by day at intervals is most important, though often almost impracticable in working-class homes. If possible the patient should rest for half an hour before and half an hour after the midday meal.

Of all the preventive and remedial factors diet is perhaps the most important. Everything should be done to improve nutrition, e.g., the teeth must be seen to, mastication practised, and excessive tea drinking and smoking avoided. A liberal amount of milk, cheese, meat and fatty food is distinctly advisable; but meat includes fish (especially herring), and peas, beans, lentils and oatmeal will to a certain extent replace animal food.

In visiting a case of tuberculosis the following are the chief points for the visitor to note and report:—

(1) Whether the windows can be and are freely opened top and bottom.

(2) If there is an obstruction to the entrance of air and light by trees, bushes, creepers, blinds or curtains.

(3) The extent to which open-air treatment is carried out. Has the patient a separate room, or separate bed?

(4) When consumption shelters are available is the patient willing to use one?

(5) Is he having regular medical attendance?

(6) How expectoration is performed and how the sputum is disposed of. Does he always spit into a liquid and never use a handkerchief?

(7) Has the patient a copy of printed directions issued by the medical officer of health or the tuberculosis dispensary, and is he attending to them?

(8) Have all the other members of the family been examined by the tuberculosis officer or their private doctor for the detection of early tuberculosis?

A tactful visitor will find opportunities of giving useful hints as to disposal of superfluous furniture, curtains, carpets and everything liable to collect dust. She should point out the necessity of wet cleansing and the danger of spreading infection by dry dusting and sweeping. Poor food and intemperance being predisposing factors, the presence of tuberculosis gives opportunity of impressing the importance of a scientific diet, and the avoidance of alcohol. Children's diet is usually deficient in fats and proteids, and the usefulness of herrings (including the roe), and other fish, cod liver oil, oatmeal, pea soup and milk should be insisted on.

A health visitor may in the course of her daily round often have her attention called to persons in failing health. Some of these are probably commencing cases of tuberculosis and the visitor should know the early symptoms of this disease. Any person suffering from daily rise of temperature over 99°, anæmia, loss of flesh, loss of appetite, indigestion, or persistent morning cough and expectoration should at once be examined by the tuberculosis officer or some doctor skilled in the early detection of phthisis. In children failure to gain weight should excite suspicion. Early phthisis is difficult to detect. When a doctor without special experience can

say decidedly that tuberculosis is present, or where tubercle bacilli can be found in the sputum, the disease is already past the early stage, and recovery though quite possible much more difficult.

The tuberculosis visitor will spend much of her time in after-care work, i.e., visiting cases who have returned from a sanatorium or hospital. She must endeavour to obtain a copy of any general and special directions, whether printed, written or spoken, given to the patient on his discharge, and see that these are carried out. The patient may require hints how to adopt the open-air principles he has learnt at the sanatorium, to his home conditions. Inquiries should be made as to diet to see that he does not go from a plain diet rich in fats and proteids to a tasty one rich in sugar but poor in the more important elements. The most difficult question for her to deal with is that of occupation. The advice often given to obtain light outdoor work is usually found to be impracticable. Where there is a marked taste and fitness for agricultural work it may be advisable to consider emigration to the Colonies, but this should only be attempted if there are friends to welcome the emigrant in his new home, and distinct assurance of a job to go to. Generally speaking, if the man is discharged as fit for work of any kind, it is better that he should go back to his old job than be idle at home. If possible the employer should be approached to see if he can and will arrange to improve the conditions of the work as regards ventilation, dust, shorter hours, &c. Of course this will require the utmost tact and consideration, and counsel should be taken of any person competent to advise and help, and the approval obtained of the "higher powers."

Tuberculosis was made notifiable in order to enable Health Authorities to see that as far as possible all consumptives received proper medical attention, and that all practical measures were taken to prevent the transfer of infection. The health visitor must, however, always remember that notification is confidential, and that she

is not justified in informing any person of the fact that a patient is infected without his consent. In practice such consent is rarely refused to a tactful visitor, but the necessity of respecting the confidence must be kept in mind, especially when the patient is a lodger; in the latter case judicious leading remarks will frequently elicit that the landlady is already aware of what her lodger is suffering from.

When the patient is being attended by a private doctor there are often obstacles to the health visitor's visits. It will be for the medical officer of health to find out whether the medical attendant will welcome the assistance of the visitor. If he does she must be more particularly careful not to suggest anything that the doctor may not approve of, and it will be desirable either to secure an interview with him or try and obtain written directions.

Influenza.

The health visitor is not likely to have to visit many cases of this disease. The usual symptoms and course it runs are too well known to need description.

There are two sheet anchors in treatment: rest in bed and open windows. Experience of the recent epidemics shows that when the patient at once goes to bed and remains there, with widely opened windows, till all acute symptoms are passed, not only is the prospect of recovery greatly increased, but the spread of infection is much diminished. Isolation of most cases is impracticable, but old people and young children should specially avoid the infection, and it is particularly important to isolate cases of influenzal pneumonia.

The fact that influenza is spread by coughing and sneezing, should suggest to the visitor the desirability of inculcating the practice of never being without a handkerchief, and of using it on every occasion when a cough or sneeze is unavoidable. This practice should be habitual to all, young and old, the well and the unwell, for many well persons are carriers.

Ophthalmia Neonatorum (Ophthalmia of the Newborn).

This disease was made notifiable by an order of the Local Government Board in the hope of preventing the numerous cases of blindness which used to result from the neglect of treatment. It is a gonorrhœal affection of the eyes contracted while the head of the infant is passing through the vagina of an infected mother. It is to prevent this disease that careful doctors and midwives always thoroughly cleanse the eyes of a new-born child, and frequently instil a few drops of nitrate of silver solution.

The chief danger is of the midwife making too light of the attack, and attempting to treat it herself. Treatment needs to be thorough, persistent and frequently repeated. Not only must a doctor be called in, but the services of a district nurse are required, unless indeed the midwife is a capable woman and able to carry out the treatment under the doctor. But bad cases cannot be treated satisfactorily in many poor homes, and in London and other towns hospital provision has been made which enables the mother and child to be moved together and receive skilled treatment and nursing.

It is, of course, for the medical attendant to decide as to the sufficiency of the treatment, but as both he and the mother are often ignorant of the nursing and hospital facilities of the district the health visitor should let it be plainly known what these are.

She should not be satisfied with providing for the treatment of the child : if the mother has a gonorrhœal discharge she also requires treatment, both for her own sake and that of the children born as well as others which may be born. She must be tactfully advised that she has infected her child and requires skilled medical treatment. If her own doctor is not dealing with her case, she may be recommended to the nearest venereal disease clinic and steps taken to see that she goes there.

It must be remembered that an infant is to some extent like older persons liable to mild forms of conjunctivitis due to other germs than the gonococci. It must not therefore be assumed in all cases that the mother of a child with a very mild form of ophthalmia necessarily has gonorrhœa. This assumption is only justifiable when the mother admits to a discharge, and possibly when the ophthalmia is distinctly purulent, or if a bacteriological examination has shown the presence of gonococci.

Puerperal Fever.

The treatment of this serious complication of child-birth will generally be well in hand before the health visitor attends, and her visit will be mainly for the purpose of inquiring as to the source of infection and reporting to the medical officer of health.

It may however be her duty in some cases to point out the local facilities for hospital treatment, and failing that the desirability and practicability of obtaining a district nurse.

Puerperal fever is caused by infection from another case of the same disease, from a case of erysipelas or scarlet fever, or by septic matter present in the vagina or introduced from outside. Thus the doctor or midwife may be responsible, but it would be a great mistake to assume that they always are. In a dirty house absolute aseptic delivery is almost impossible, and occasional cases of puerperal fever occur in the best managed lying-in hospitals. But it is true that if the same precautions were taken by all doctors and midwives in home practice as are practised by nurses, midwives and medical staff in the best maternity hospitals, there would be very few cases of puerperal fever to notify. Probably some cases are due to gonorrhœa.

The medical officer of health will wish to have as much information about the case as can be obtained, e.g., the full history of the illness, possibility of overlooked cases of erysipelas, scarlet fever, gonorrhœa, &c.,

name and history of midwife, whether any other person than doctor or midwife in attendance, cleanliness of room, &c. It is often very difficult to get some of this information, as it is particularly important to avoid disturbing the mother, and the midwife may be unwilling to say much. It is better to postpone inquiries than to ask any questions which may reasonably be objected to.

The mother will probably be too ill to nurse her infant. In that case it will be for the health visitor to advise as to artificial feeding. If, as often happens, the child is removed to another home, the visitor must inquire the address and follow up the case, referring it if necessary to her colleagues in another district of the borough, or if moved out of the borough, report the case to the medical officer of health for him to deal with by notifying to the borough in which the new address is situated.

CHAPTER VII.

VISITING, OFFICE AND COMMITTEE WORK.

THE work of the health visitor has been rendered very much easier since the Notification of Births Act 1907. She receives a daily list of all infants born in her district and can plan to visit them at whatever period she considers convenient.

HOW SOON TO VISIT.

When she is well known in a district so that the majority of mothers are already known to her she may visit very soon after birth, but if she has not previously known the mother, about fourteen days after the birth has occurred is usually considered the best time for the first visit. This will avoid clashing with the midwife, and will be in time to catch the mother if she is going out to work before she has begun, and occasionally to prevent this tragedy taking place.

WHOM TO VISIT.

Some Medical Officers of Health permit or advise the health visitor to call at *every* house in the district irrespective of the social position of the parents. (This was the system adopted in the City of London for some years.) Most health visitors find it convenient to devote their whole time to what are termed the "working classes" and they will be wise if they include people of the shop-keeping class amongst these, for once the ice is broken the more refined and the better homes people have, where their means are small at any rate, the more valuable will be the clinic and its activities to them. They help

to set a nice tone to a centre and are usually a great acquisition.

If however, in breaking open a new district, or worse still coming to a place where the previous health visitor has not been held in good repute ; the health visitor finds that she meets with opposition from this class, she must use her judgment as to whether she should ignore the cold looks and continue visiting until she has established her reputation, or confine herself to the poor only for the start off.

When Mothers are Out.

A good visitor must be resourceful, tactful, a ready speaker, very observant and above all persistent. In fact, she must put her whole personality and character into the work in order to be successful. For instance, many mothers are *out* when the call is first made, it should then be repeated after a short interval ; if again out, an inquiry from a neighbour, if possible, will often elicit the fact, either that the address is wrong or that the mother has gone away or that she spends the day with her mother, &c.

In any case, the fact must be noted and the case followed up wherever possible. It is in cases like these that a good memory is so essential. Most health visitors carry addresses where they have failed to gain entrance at the back of their minds and are on the look out whenever they pass the house for signs of life. The same plan applies to a revisit where the mother is always out.

Revisits.

The health visitor must not call too persistently as she might if she were hunting down a case of cruelty when any means might be justifiable ; but she must never be satisfied until she has found the solution to the difficulty. When she is well known, it hardly ever arises as the neighbours attending the centre will be

constantly telling both her and their friends about any baby who is not known to her.

Then, supposing the health visitor finds the mother at home, she must do her best at the first visit to ingratiate herself with the mother.

Opposition.

The writer has for long years so rarely met with opposition of any kind, that she has to cast her memory back to her pioneer work in a northern town. Here opposition was mostly very good natured and usually yielded to blandishments. Practically the only cases of opposition the writer can remember for the last few years were those pitiable cases of mothers who made a pretence of being superior, and were anxious to keep out the visitor, because they knew their children to be suffering from specific disease and were ashamed of the fact. Practically speaking, then, opposition to a tactful health visitor's entrance does not exist, but there are many other forms of opposition she has to contend with and I will deal with these seriatim.

Quite a large proportion of the mothers are genuinely pleased to be visited, eager to be advised and good at following instructions when given. The way is then clear, the mother will either attend the centre or if she is unable to come for any reason, she must be looked up again from time to time.

First Children.

First children should be visited much more frequently than healthy second or subsequent children, and every effort must be made to get the mother to attend the welfare centre especially for the classes.

Artificially Fed Children.

Artificially fed children should be looked up often, particularly in hot weather, and special care taken to see whether the method of feeding is satisfactory and

to insist upon the child being medically attended if it is not thriving. Foster children, orphans or children with ailing mothers require particular attention.

The health visitor should use her influence to the uttermost to prevent nursing *mothers going out to work* (except perhaps office cleaning or part time jobs); she can often represent to the mother the injury she is doing her child, and except in the benighted cotton country she will usually get the endorsement of the whole working class. How often has the writer heard working men and women say, "I reckon them crêches are wicked and ought not to be allowed."

Problem of the Illegitimate Child.

The problem of the illegitimate child is still unsolved. Until some scheme of care for *every* illegitimate child has been evolved, the best thing for the child when the mother has to return to work is a good foster mother; and if the mother can return for dinner and continue to partly breast feed it, it may do very well indeed. The writer has known many such happily and successfully reared.

'Unteachable Mothers.'

Now as to difficulties, there are a certain number of mothers who are apparently unteachable, at any rate with their first child. If they are able to breast feed, the evil is less manifest at the beginning, but later on if they bring their children to the clinic they seem incapable of following any advice except the last they hear which is usually wrong. They are a great trial to patience. Sometimes they obstinately contest every point; more often they agree to everything but never really listen or follow out anything properly. Occasionally they are shaken by their child's serious illness and become more rational. Sometimes they become attached to the health visitor and the centre and yield a very little to chaff but not often. A certain number of them,

if not all, are *mentally defective* and the health visitor must not waste time on them that might be more profitably spent.

Then there is the mother who apparently seems impressed by the health visitor's advice but is being influenced by somebody else, it may be a friend or the child's grandmother.

Relations with Doctors.

Sometimes the child is *under a doctor*. If the mother is taking the child regularly to a doctor, whether a private one or attached to some hospital, the health visitor must be very careful not to go against his advice even if she thinks she knows it to be entirely wrong. However, that is no reason for leaving off visiting. Quite a number of mothers are in the habit of misquoting their doctor or carrying out his directions wrongly. If the health visitor is patient she can usually in the end gain her own way, that is, get the mother to tell her how she is mixing the food exactly; very often it will be found that the doctor's directions are not being carried out at all. For instance, the writer once visited an infant who was attending a hospital and not thriving, and the mother had been given written directions as to mixing the milk which she declared she was following. The milk measurements were given in *tablespoonfuls*, and on asking to see the tablespoon used it was found to be the size of a large soup ladle; the child was receiving just twice as much milk as had been ordered! Then, many mothers start with a doctor and do not continue to take the child until it is cured, for caprice, or because it is too expensive, or for some other reason. There are many ways of overcoming these difficulties. The commonest procedure now that infant welfare centres are so prevalent is to persuade practically every mother whose child is ailing to attend one, unless she is attending either a hospital for some special complaint, or a private doctor. In the first case she must be kept in touch with so that she may bring

the infant to the centre when she is discharged from the hospital. In the latter case, several courses are open : (1) she may be revisited when the child is better and the mother has ceased to go to her doctor any more ; (2) the health visitor may invite the mother if the complaint is likely to be of long duration, such as some kind of malformation, to attend the centre for weighing and keep on with the doctor for the medical advice.

A health visitor in a district where there are many private doctors should, whenever possible, get to know them and establish good relations with them, and they will then be of the greatest assistance to her, and in the writer's experience private doctors have frequently sent children to the health visitor and to the centres. If there is no centre near enough for mothers to take children and they are unable to afford a paid doctor, very often the health visitor can make herself known to the hospital or infirmary through the M.O.H., and introduce cases to them by sending her card. In large towns, some system of this sort is often in operation through the centres, and for years before centres became accessible to all, the writer adopted a system of this kind. The greatest difficulty that the health visitor has to meet with is an occasional case of wrong medical treatment, very often in connection with some crowded free mission or dispensary where infant welfare is not a speciality. Here great tact is needed, but every year this question gets less acute as such places tend to refer non-thriving infants to a hospital. It would be very improper for a health visitor to interfere between a doctor and his patient ; at the same time a mother sometimes sees for herself that a child is not thriving and tries a change of treatment, and an experienced health visitor must be able to bring about such desirable changes without apparent interference. In all such cases the health visitor must ask the advice of the M.O.H. and be extremely careful to avoid clashing with the medical profession. On the other hand, she must strongly advise mothers against taking casual advice from

druggists, and certainly an assiduous health visitor sends many patients to their doctors. Very often she can get to know the doctors naturally and easily through asking them to sign certificates for convalescent homes, &c. Places vary very much in this respect, and the health visitor must always be very circumspect in her dealings with a doctor's patients, while at the same time managing to get the best medical advice procurable for those who consult her on the subject.

Abortifacients.

The health visitor will very quickly find herself faced with the difficult question of *abortifacients*. So many children are born delicate from the violent attempts made to get rid of them at an earlier period, that it is idle any longer to adopt the early Victorian method of pretending not to see questions likely to be offensive to delicacy. The Local Government Board so far recognized this as to publish a pamphlet on the practice of taking lead salts as a means of procuring an abortion; but to lecture mothers on this matter without at the same time being prepared to go into the question of preconception methods would seem to be impracticable. It is to be hoped that this whole question will soon be rationally discussed by doctors and others engaged in the Public Health Service, and a policy of clear teaching given on the subject. The health visitor must be prepared to face the matter with an unbiassed mind and form her own conclusions. She must of course point out the great danger to health of the use of abortifacients.

Infantile Mortality Visits.

Infantile mortality visits are still carried out as a routine in some districts, in others this practice has been dropped. In a small district it may be worth while to continue the routine visits, especially when nearly all the children and mothers are previously known to the health visitor. The number of questions asked and the form of inquiry

should be as brief as possible. The more elaborate the inquiry, the greater the danger of placing the record first and the future welfare of the mother second. Local Government officials, as a rule, are freer from this particular form of foolishness than are either Government departments on the one hand or voluntary societies on the other, but there are still districts known to the writer where the unfortunate health visitor is expected to obtain answers to a long schedule of questions. (See Appendix VI for births and deaths inquiry forms.)

If a health visitor is successful in her methods and establishes good relations with the people in her district, she will soon be recommended from one to another and be in great request. In fact, her difficulty will be not to get in to the homes but to get out! She must be on her guard against wasting time by talking on matters unconnected with health, fascinating though she may find it, and yet she must resign herself to listen patiently to a good deal of talk from the voluble before being able to get in her points with some hope of their receiving attention.

Office Work.

Record Keeping.—In some districts the medical officer of health designs his own form of records in which case the health visitor is saved the trouble. In others, the matter is left entirely to the health visitor. The following forms of records the writer has found useful but they are of necessity only a rough guide. Districts vary and what is suitable for one may be inapplicable to another. These records can easily be adapted by the addition of further details to any district.

Births.—The card system is the best method for this. The cards should be arranged in alphabetical order according to streets and kept in a box so that any case can be referred to in the minimum of time. A good method is to label the front of the box: "Births, January, 1920-21," keeping the years in separate boxes and destroying the cards after the children have passed to school

age, and using the box over again. Otherwise there would be an enormous collection of cards in ten or twenty years' time, which are really quite useless once the child has passed beyond visiting age. People who worship records would probably keep all cards for ever, but I have already spoken on this subject. Each card should have the front and back made out in the manner indicated.

See Appendix VII for specimen card. The important points to remember are :—

(1) Strict accuracy. Every card for instance, must have the year as well as the month put under the date of birth, for although this is already on the box, if the M.O.H. requires to refer to cards for any reason and they are temporarily removed from the box, in replacing them it becomes difficult to ascertain which year they belong to unless it is stated on the card.

(2) Records must be kept absolutely up to date. If a health visitor is suddenly taken ill and prevented from returning to work, her substitute should be able to see at a glance exactly the position of each case on the cards ; not only for this purpose but for the sake of the health visitor's pride in her own work, any slovenliness in record keeping should be strictly avoided. It must be remembered that the Ministry of Health and the medical officer of health have little other chance of knowing how the health visitor does her work except by her records. She should always be willing to provide reports and statistics on any part of her work at short notice.

(3) The system of records must be complete. Whatever method is adopted for co-ordination of all the cases it must leave no loophole for unrecorded visits or omit important events. Taking the card box in further detail—

When a birth is notified, the columns :—address, name, date of birth, legitimate or illegitimate (if known), attended by doctor or midwife, &c., should be at once filled in and the card placed with all other unvisited cards until the child has been visited. Directly the visit

has been paid, while the details are fresh in the health visitor's mind as well as in her notebook, the card should be filled in and placed in the box in alphabetical order. Boxes should not hold more than 500 cards when full. In a large district, there should be as many boxes as there are wards or other divisions of the district. It will be found convenient to place some sign on the top left hand corner of each card that either requires no longer to be taken out of the box and scanned by the health visitor, or requires special attention. Thus D for dead, R for removed, on the one hand, and O for ophthalmia neonatorum, W for mothers attending welfare centres on the other hand, will enable the user of the cards when running through the box quickly, to see at a glance what is on these cards. It is necessary for the health visitor to constantly turn over these records, making lists of those requiring revisiting, and always adding at once to the card any relevant information she may acquire about the infant.

In some places, a system obtains of grouping the cards according to the dates of birth. This is a bad method, because if reference is required quickly for any case, unless the exact age is known it cannot be found, and the test of a good record is that it should be easily accessible.

Daily Journal.—Besides the cards, the health visitor will be required to keep a daily journal. The most useful form of journal is the one that states the name and address, and the nature of visit and action taken in parallel columns. Thus:—"Wilkinson, 4, Devonshire Street, Infant's birth, fourth child, naturally fed, left leaflet"; is quite adequate for a normal birth visit. The journal should be indexed at the end by all addresses being entered with the number of the page of the journal. This is of additional use when the health visitor wishes to do revisits. The journal being kept daily, she has only to turn back to one, two or three months earlier and see what births were visited.

For visits to verminous children, and various odd visits, the journal may be the only record, in which case full details should be given. Where, as in the case of measles inquiries, a separate sheet is filled in, it is enough to put in the journal, after name and address, "notification of measles, see special sheet," and thus save reduplication of records.

As regards names on the birth card it is important to always observe the same order in the placing of the surname and christian name so as to avoid confusion. Thus surnames should always be placed first and christian names following; the writing must be clear. If the health visitor is so unlucky as to have illegible handwriting, she had better take pains at once to change it. There is nothing more annoying than badly written or untidy records.

Infant mortality records are usually kept in a book for the purpose. The headings found sufficient for ordinary inquiries are in Appendix VI.

Although all cards, &c., should be filled in at once, statistics, and quarterly and annual reports may well be left for very wet weather.

Correspondence.—Other office work includes letters, both sending and answering them. Some letters are better answered directly by the M.O.H. The rule is that correspondence should go through the M.O.H., and the health visitor should only answer letters by his instruction, but in many cases the correspondence is left to the health visitor's discretion.

Others the health visitor should answer herself, in every case making a short *précis* of the letter sent unless a complete copy be held to be desirable. A considerable proportion of letters received in a town will be from hospital almoners respecting cases applying for lying-in accommodation and asking for details as to home conditions or requesting a visit. All letters should be answered as soon as possible giving whenever necessary the required information.

The health visitor will often have to write herself to convalescent and holiday homes about mothers and children, to the National Society of Prevention of Cruelty to Children, a most valuable adjunct in cases of suspected cruelty, and sometimes to mothers who have left the district either temporarily or permanently, and who write asking for advice. It is better to pass on to the M.O.H., whose clerk can answer them, all letters complaining of dirty conditions in houses; but various methods are adopted by M.O.H.s in this respect, and it is the health visitor's business to adapt herself to his wishes.

Interviews.—Under the heading of office work may also be counted interviews. Usually a definite time is fixed for interviews when the health visitor may always be found in. When the person calling knows his business, gets through what he has to say as quickly as possible and then goes, the interview is a pleasant form of work. Mothers with infants and sometimes fathers calling for advice are easily and pleasantly dealt with and rarely trespass too long on the health visitor's time. Rather trying to patience are the voluble people, very often voluntary workers of some kind, who come round and complain of conditions which the health visitor is powerless to put right, and who, when told this, begin all over again. Still more annoying are the various students of "social service" who take up a great deal of time talking about one case, and then so obviously that one can see the wheels turning try to "establish friendly relations with the official" by asking a great many leading questions on the work. One call from such can be borne patiently, but some of this species have a perfect genius for making themselves nuisances to a busy official. The health visitor is advised to make it quite plain courteously but firmly that she is not there to have her brains picked and her time wasted by any such unasked for visits. On the other hand, co-operation with other workers is better brought about by an occasional good talk than by any other method.

The probation officer, the school nurse, the relieving officer, the secretaries of the unemployed and emigration committees, &c., all ought to work in touch with the health visitor. She must be prepared to render and receive assistance from all of these. She had better be very careful to dissociate herself from any organized voluntary association working among the poor. Any society connected with the giving of relief is sure to make enemies among those it has had to disappoint, and it does not do for the health visitor to run the risk of having her sayings quoted back to the people, as if her opinion is asked about a case, they are pretty well bound to be.

The health visitor should never be connected with relief of any kind more than being able to say to the mother, "If you come to the centre we will see if you are eligible for our milk grant cases." Sometimes clothing and other gifts will be presented to her for distribution. Before the advent of infant clinics this was a delicate matter, as it entailed either asking people to call and fetch the parcels at the office, or else the health visitor had to carry them round to the homes. If the health visitor is not very discreet in dealing with such exceptional windfalls, she will be visited by many people asking for favours, and will have cause to regret that she ever undertook the duty.

Another kind of visitor, who was very prevalent before the war, was the traveller or agent for various kinds of patent foods and dried milks. Considering that some of the best dried milks first came into use through municipal use, it does not do to have any prejudices on this matter, and always acting in consultation with the M.O.H., the health visitor may find that some of these dried milks provided on favourable terms may prove a valuable adjunct. On the other hand, the health visitor should refuse to have "any truck" on any terms whatever with many patent foods that are known to be unsatisfactory, be the terms ever so favourable.

Proficiency in Office Work.—The health visitor should be a very quick writer and indexer, and have the capacity to work without getting irritated by frequent interruptions. A dawdler will soon get behind with record keeping, and will then have to spend time that ought to be devoted to visits in indoor work. Office work often seems extremely irksome to one who prefers outdoor work, but the remedy is to take pains to make oneself as proficient as possible at it, and thus perform one's indoor duties in the minimum time.

Committee Work.

Most health visitors will be called upon to serve upon a committee in some capacity. The difficulty is to avoid wasting time that might be more profitably spent otherwise, and yet to keep in touch with the various organizations affecting health visiting.

There are districts where almost the whole time of one health visitor is spent in committee and office work, but this is a great mistake, as the proper work of a health visitor or sanitary inspector is visiting, and if she is deflected from this then the opportunity of work for which she has obtained special experience is being wasted. It takes years of experience as well as natural ability to make a really good visitor, so that unless the health visitor is head of a very large staff and has to direct them and instruct newcomers from time to time, she should take care not to allow herself to be swamped by committee work.

Council Committees.—Where it is the custom, she should always attend either every meeting or in rotation the meetings of the maternity and child welfare committee appointed by the Council, as she will thus be able to see exactly what is going on; and when she has gained some experience of the ways of committees she will be able with the assistance of the medical officer of health to get her own way on many points. Let her beware though of speaking at the meetings unless appealed to

first, as there is a strong feeling in all municipal committees that the councillors and not the employees—least of all the subordinate employees—are there to do the talking. However, this does not prevent a good deal of surreptitious conversation with the more friendlily disposed councillors, many of whom enjoy a talk with the subordinates, who after all are doing all the work.

It is usual to ask the health visitor to read her own report of the infant welfare work done for the month or quarter.

Sometimes this gives rise to useful suggestions of practical help. It also gives one an idea of how very little people are able to take in of figures when read aloud to them, and for this reason the health visitor should always try to give some of the facts in a form that every one can take hold of ; mere lists of visits and numbers of infants attending centres leave most committees quite uninformed unless they are particularly interested in the subject at issue.

Voluntary Committees.—It is desirable that the health visitor should attend the committee of any voluntary society connected with infant welfare where she is in the habit of assisting at the clinics. Here her position on the committee is a very different one to that of a subordinate employee attending the council's committee.

She votes on all questions, she is often asked to represent the committee, and takes part freely in all the discussions, and her opinion carries great weight.

In rare cases it may be advisable for the health visitor to serve upon other committees, such as the Charity Organisation Society and other bodies affecting working-class people; but usually she will find it better to concentrate on the one sort of committee and make a point of attending it regularly and giving all the assistance she can as a member of committee as well as in the capacity of a health visitor.

CHAPTER VIII.

THE ASSOCIATION OF INFANT WELFARE AND MATERNITY CENTRES.

AMONG the many organizations that aim at helping those who are engaged in the now "fashionable" infant welfare movement, there is probably none more popular and certainly none older than the Association of Infant Welfare and Maternity Centres. This organization, which is a section of the National League for Health, Maternity and Child Welfare, was founded in 1911, when there were less than a hundred centres in existence, among which, however, a desire for that strength that comes from union and joint action was already manifest. As a first step, amalgamation with the Society of Medical Officers of Infant Consultations was effected, and although the medical and the lay elements of the committee worked at first in somewhat watertight compartments, it was soon found that the one was the necessary complement of the other. Henceforth the two sections became one, co-operating at all times most loyally and harmoniously.

It has always been the policy of the Association to leave its affiliated centres to develop on their own lines, only suggesting methods of work or new developments, sometimes after experimenting on them itself, when asked for such help. The Association has, however, from the outset insisted that infant welfare work to be worth doing must be on a firm medical basis, and that infant consultations could only be recognized as such if every child under 6 months of age, whether well or ailing, were seen by the doctor-in-charge at least once a month. Only during the war, and on account of the shortage of

doctors, were centres admitted to provisional membership in the Association, though they did not conform to this standard. Another point on which great stress has always been laid has been the need for voluntary infant welfare organizations securing the co-operation of the local authorities concerned. It may seem strange now-a-days that it should have been necessary to insist on this, seeing how much of the work is now entirely in the hands of the local authorities. It must, however, be remembered that the pioneer work for this movement, as for so many others, was carried out by voluntary organizations, many of which, rightly or wrongly, were keen on maintaining their independence and dreaded interference by officials. In the long run the policy of the Association in both respects was found to be justified, and not a few centres mended their ways, both with regard to medical supervision and co-operation with the powers that be, in order to qualify for membership. There is no doubt, too, but that preliminary working together with the Authorities paved the way for taking over many of the voluntary bodies by the municipalities and county councils, while still retaining some of the voluntary elements—a policy which is now found to work so well.

The three chief aims which the Association has consistently kept before it have been : (1) to maintain, and, where necessary, to raise the standard of the work done ; (2) to link together those who are doing that work, and to facilitate their task by bringing the experiences of each within the reach of all ; and (3) to carry out investigations into, and where possible initiate, new developments connected with the movement.

Several means have been employed for maintaining and raising the standard of the work done. The preparation and publication at a cheap rate of standard case papers and other record-keeping documents has proved a very useful measure, to judge by the fact that the Association's case papers, &c., have now been adopted

by a very large number of local authorities and voluntary agencies throughout the kingdom and even beyond it. The Association's many text-books on mothercraft, designed for various classes of the community, from mothers attending the centres up to the professional infant welfare workers themselves, are in constant demand, and are regularly revised and brought up to date by the many medical experts who are responsible for their production. But even more helpful and stimulating than these have been found the National Mothercraft Competitions, organized annually by the Association among its affiliated centres, in connection with which a handsome and much coveted silver challenge shield is awarded every year. A healthy spirit of emulation and of friendly rivalry among mothers, workers, and centres has undoubtedly been fostered by these competitions, and the number of centres, both municipal and voluntary, in London and the Provinces which take part in them increases steadily from year to year.

The competitions are so arranged that while the competitive element is well to the fore, working to standard is also encouraged. In the first place, every centre is represented only by one mother in each of the six classes for which it may enter. This makes them very critical and equally keen in selecting their cleverest exponent of the various phases of the art of mothercraft. A wide selection of subjects, which include written answers to simple questions in mothercraft and home nursing, writing a letter or essay on some selected aspect of the craft, making, knitting, mending, renovating, making-down, or washing garments, cooking, cobbling, toy-making, family budgets, &c., give opportunity to all to excel. All who come up to a certain standard, as evidenced by the percentage of marks awarded, receive an honours, first or second class certificate, and it is very rarely that a competitor does not gain one or the other. These certificates in their turn decide the award of the Challenge Shield, each counting as so many marks towards it—an honours

certificate is worth 12 marks, a first class one 8, and a second class one 4 marks. Every year the standard of the work submitted improves and the rivalry for the first place becomes keener and keener. In 1920, for the first time, out of sixty-five centres competing, two scored the same for the top place—64 marks on certificates out of a possible total of 72. It was only by adding up the actual marks awarded to each mother in the class for which she competed, that it was found that the mothers attending the St. Pancras School for Mothers had done a little better than those of the Welbeck Street Branch of the St. Marylebone Schools of Mothercraft, and so the former gained the shield for the second year in succession. The excitement over the announcement of the award of the shield was never greater than on this occasion of a tie. When the difficulty that had occurred was put to the assembled gathering of 250 mothers—not to mention the babies—one would-be Solomon suggested, "Cut it in half!"

There are always two or three classes for which fathers can enter instead of, or as well as, mothers and remarkably well they do, too. The applause is well-nigh deafening when *they* come up for their certificates.

The regulations which compel all competitors to enter for the examination in *Mothercraft* (a set of questions sent in a sealed envelope to each infant welfare centre on the day of the examination, and for which as many mothers as can be induced to, sit for examination, the best paper being sent up to headquarters) and which also compel the superintendent of the centre to send up the medical records of each infant of those mothers whose work is submitted to headquarters, this forming a competition for best kept records, is an interesting feature of these competitions. The improvement thereby effected by the centres in their method of keeping records has been most marked, and it is rare now to receive at headquarters only a few more or less illegible notes scribbled by the doctor on stray pieces of paper and accompanied

by an ill-kept weight card. One feels, too, that the superintendents are being encouraged and helped to improve the standard of their teaching and to keep it up-to-date. Without some incentive of this kind, it is certainly hard for workers in isolated rural areas, for instance, to persevere in their uphill educational efforts, and it is certainly helpful to all to see what other centres are doing and teaching. The best of the written work is always published subsequently in *National Health*, and it is hard to believe sometimes that these well-expressed thorough essays or examination papers are from the pen of uneducated mothers who have nothing but their practical experience and careful teaching at their centres to go on.

It will be noted that no prizes are awarded, nothing but simple, well-printed, attractively designed certificates, which are evidently greatly prized. Competitions for actual prizes, whether large or small in value, cannot fail to cause jealousy and so defeat their object.

It may be said that to have only sixty-five centres competing out of the 2,000 now existing throughout the Kingdom, 1,300 of which are municipal and 700 voluntary, with about 400 of the former and 300 of the latter affiliated to the Association of Infant Welfare and Maternity Centres, is a very small proportion and so it is. It must, however, be remembered that entry entails steady educational work over several months in the year and only the largest and oldest established centres can or do undertake this, understaffed as so many are, with consequently overworked officials. Moreover, it is sad to find from considerable experience that the more municipal control and action replaces that of voluntary agencies, the less stress is usually laid on the educational and social aspects of the work, in contradistinction to the strictly medical and health visiting aspects. Many of the present health visitors, who are largely responsible for the centres, except those in the large cities, have no time to do more than visit in the homes, weigh the babies at the centres, or generally supervise the work done there.

Besides this, their training has in most cases not prepared or fitted them for *teaching*, which also calls for the exercise of special gifts.

Largely instrumental as the Association undoubtedly was some years ago in securing Government recognition and financial aid for the centres at first, and later on for maternity and child welfare work generally, it has been equally active in securing for the professional workers a more recognized status and more adequate salaries. The recent publication by the Association of the results of an inquiry into the scale of salaries obtaining among workers at municipal and voluntary centres, led many authorities and others to add to the meagre pay previously given. The workers are also linked up, at least as far as London is concerned, by means of the Workers' Section of the Association, which has already done useful work in organizing helpful discussions on doubts and difficulties or on new developments as they opened up, and in airing and securing redress of grievances. All these activities form valuable links between the workers. What is now wanted is an extension of these links, by forming further sections for workers throughout the Provinces, and still more by dividing up the work done at headquarters among regional federations. It is hoped that these will shortly be formed throughout the Kingdom, either spontaneously, or with the help of the Association itself, to which the federations would no doubt be linked, however loosely. The London Federation has now been in existence for over a year and has abundantly proved its worth. The movement has grown too large and too widespread to derive all the assistance it needs from a Central Committee, however representative of London and the Provinces it may be. But the Central Committee will always have many useful and well-defined functions to perform, and will continue at all times ready and willing to assist the movement to the best of its ability, withouf interference or coercion of any kind.

CHAPTER IX.

THE TUBERCULOSIS VISITOR.

History of our Knowledge of Tuberculosis—Nature of Tuberculosis: Infection and Immunity—The Allies of Tuberculosis: Poverty, Ignorance, Drink and Dirt—Importance of Environment, (*a*) at Home, (*b*) at Work—Variations in the Incidence of Tuberculosis between (*a*) Men and (*b*) Women (see Appendix VIII (*a*) and (*b*)).

History of the campaign.—Defensive and offensive methods: treatment and prevention.—The campaign under private enterprise: voluntary treatment, voluntary visiting and voluntary notification.—The campaign as a form of communal effort: compulsory notification, provision of treatment by the community, visiting on behalf of the community.—Communal effort still only partially exerted because the extent of the danger still only partially realized.—What stands between us and victory?

(*a*) *Introductory.*—Home visiting an essential feature in the campaign, whether defensive or offensive. Education of patients and of their families necessary, as to the nature of the disease, its cause, treatment, and prevention. —After-care.—The visitor essentially a teacher and a friend.—As a teacher, the visitor must have knowledge, the ability to impart it, and a sense of vocation in the public service.—As a friend, the visitor must have personal sympathy with, and liking for, the patients and their families, as well as an intimate knowledge of the circumstances of their daily lives.—The visitor must learn, teach, and convince.

(*b*) *What a Tuberculosis Visitor ought to know*: (i) of the disease; (ii) of men, women and children; (iii) of social conditions.

(*c*) - *What a Tuberculosis Visitor ought to do* : (i) in prevention ; (ii) in treatment ; (iii) in after-care.

(*d*) *"Don'ts" for the Tuberculosis Visitor.*—Don't forget you are a visitor, and therefore a guest.—Don't be official.—Don't use long words.—Don't forget that each patient is a person as well as a case.—Don't think in "cases," medical or social.—Don't overwork.—Don't hurry.—Don't despair.

(1) Tuberculosis, the Enemy.

Tuberculosis—and more especially pulmonary tuberculosis—has long been recognized as a powerful enemy of human health and happiness. A generation ago, pulmonary tuberculosis (i.e., consumption, or phthisis), was included, both by the medical profession and by the general public, in the list of incurable diseases, which included cancer and leprosy. The belief that consumption must necessarily pursue its course unchecked until it causes the death of the patient is, indeed, still widely held. "To go into a decline," "to fade away," "to melt like butter in the sun," are all popular descriptions of the disease, in different parts of the country. Too often, a young girl suffering from consumption is the centre of a morbid, sentimental and thoroughly unhealthy attraction, based on the belief that an early death is inevitable—more especially if "her poor mother went that way before her." To those who hold such a belief, the suggestion that any form of treatment can arrest the disease appears, not only futile, but almost impious. Fortunately, it is by the grandmothers that this belief is most firmly held ; part of the task of the tuberculosis visitor is to prevent its being handed down to their children and grandchildren.

This belief, like other forms of superstition, is founded on ignorance. In this case, ignorance, as to the cause and treatment of tuberculosis was, indeed, almost complete, not only among the British public, but also among members of the medical profession, until a generation ago. In Europe, the Italians were the first to recognize the infectious

nature of the disease—is it not Madame de Staël who, in a letter written from Naples, about 1820, describes the compulsory burning of a house with all its contents on the death from tuberculosis of its late occupier? This was in accordance with the law passed by Ferdinand VI in 1746.

The importance of fresh air in the treatment of consumption was first pointed out by an English village doctor—George Bodington, writing in 1840—though it was not until 1859 that the first sanatorium was opened, at Görbersdorf, in Germany. There was, however, no exact knowledge of the cause of the disease until 1882, when Koch, in Germany, discovered the tubercle bacillus. Research by the Russian professor, Metchnikoff, working in Paris, revealed much more of the life-history and activities of this bacillus, and pointed out the path to be followed in all methods of prevention and treatment of the disease. Further research, especially into the uses of vaccines and drugs, is still proceeding, and may lead to new forms of treatment. The recognized course of treatment at all sanatoria, however—fresh air, suitable and sufficient food, and graduated rest and exercise—has been proved sufficient to check the disease in the majority of early cases. Whether the check remains permanent or not depends, apparently, on two other facts—the duration of the treatment, and the conditions under which the patient lives after treatment. In more technical terms, the disease can usually, in early cases, be rendered "quiescent"; the other two factors determine whether or not its course will be "arrested."

In order to understand this, and other peculiarities of the disease, intelligently, it is essential to know something, even though only in the broadest outline, of the bacillus in question. The tubercle bacillus or tubercle rod is a germ enclosed in an envelope consisting chiefly of waxy substance. This envelope gives it a protection from such external influences as drying, heat and cold, which is not possessed by most other bacilli, for example, the typhoid

bacillus. The tubercle bacillus is therefore very resistant, and can survive for long periods in dust and in the human body when it is embedded in lung tissue causing pulmonary tuberculosis.

In the latter situation it is attacked by certain white cells of the blood called phagocytes and also by the connective tissue cells of the lung substance. If the individual is in good health and other conditions are favourable, the bacilli are destroyed and broken up. No more is heard of them, because they are absorbed by the blood and tissue cells. In this struggle the body cells are stimulated to fight by the poisonous substances which the bacilli themselves pour out. If, on the other hand, the individual has poor resisting power, then the bacilli prove the victors. The blood cells and the tissue cells are destroyed. This results in the formation of the "grey tubercle," a mass of dead phagocytes and connective cells in concentric formation surrounding the bacilli. This mass is about the size of a pin's head; many of these masses exist in a lung which is invaded by tuberculosis. If the disease progresses, the poisons poured out by the bacilli become very virulent. The "grey tubercle" becomes larger and softer. The dead cells become yellow and cheesy in consistence, the "caseating nodule," which finally breaks down into yellow fluid pus and is coughed up as sputum. The sputum in such a case contains, besides dead cells, portions of elastic fibres of the lung substance and bacilli. Sometimes these caseating nodules run together, forming larger nodules, and when they are coughed up a cavity results.

Tubercle bacilli can be conveyed to the human body by (1) inhalation, (2) ingestion, (3) inoculation. In the first method the bacilli may be inspired directly into the lung by breathing air which is contaminated by tubercle-infected dust or by inhaling droplets of spray from the coughing or sneezing of a consumptive. It is equally, if not more, probable that the bacilli are not inspired

directly into the small air chambers in the lung substance, but that they reach the lung in the lymphatic stream, having in the first instance been absorbed into the mucous membrane of the mouth, tonsils, bronchi, the lymphatic glands surrounding the bronchi, or even by the more distant route—the lymphatic glands in the abdomen. The latter route occurs more frequently when the bacilli are swallowed (ingestion) in infected food, such as milk, butter, cheese and meat, &c. In this case it is likely that there will be signs of tuberculosis in the abdomen as well as the lungs. Inoculation is a rare method of infection, but an example is on record where a shaving cut near a consumptive's lips became tuberculous from infection by the saliva.

The general poisoning and anæmia which are marked features of progressive tuberculosis are caused by the toxic products of the bacilli. They act by destroying the hæmoglobin or oxygen-carrying matter of the red blood corpuscles. Less oxygen is supplied to the body for its needs. The hæmoglobin is poor in quality and in colour, hence the pallor of anæmia and the breathlessness. The lungs have to work harder in order to compensate for the diminished oxygen-carrying capacity of the blood, and this task is rendered more difficult from the fact that areas of the lung tissue have been put out of action or destroyed by the activities of the tubercle bacilli.

It is to this secondary process that various authorities attach varying degrees of importance, treatment by the injection of vaccines aiming generally at the counteraction of the waste-products, in order to render the patient immune from their effects.

This brings us to the whole question of immunity with regard to tuberculosis. So far, resistance to infection has been regarded primarily as the work of leucocytes at the point of invasion. There is, however, a second form of resistance—the counteraction to the poisoning of the blood-stream by waste-products. This takes place by the

formation of other products, which absorb the waste-products of the tubercle bacillus, thus rendering the patient immune. The formation of these immune bodies in the serum may be natural or it may be artificial. Little is, as yet, known of the natural process of the production of immunity. We know that it exists, because in healthy communities into which tuberculosis is introduced for the first time, the result of infection is far more generally fatal than it is among the population of industrial towns. In any large industrial town at the present day, these germs, ejected in spitting, are present in large numbers in the air, carried in dry sputum on the dust of the streets, of houses and of workshops. It is practically impossible for a town dweller to escape from infection—a series of tuberculin tests on London school children gave a positive reaction in 95 per cent. of the cases tested.[1]

It is clear, however, that 95 per cent. of the population of London is not suffering from active tuberculosis—even in famine-stricken Vienna the percentage is not above 60. Something beyond infection is therefore clearly needed to produce the disease in any recognizable form—or even to proclaim the infected person a "suspect." This is accounted for by the fact that persons living in an industrial area constantly receive small doses of infection, spread over a long period, producing immune bodies in the serum all the time. Primitive, healthy people, on the other hand, such as the Kanakas of the South Sea Islands, not being "tuberculinized" in this way, receive a large initial dose of the infection, to which they succumb.

Evil as are the results, as shown in the number of children

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[1] Infection through tuberculous milk—the germs in this case coming from the diseased udder, or other organ, of a cow—is also probably very general in city children, though, as the children who drink most milk are the children whose parents can provide them with abundant fresh air, food and sleep, the consequences of infection through milk are probably far less disastrous than is sometimes supposed.

suffering from crippled backs and limbs, and energetic as the measures for promoting a clean milk supply should be, the proportion of persons suffering from these "other forms" of tuberculosis is very small compared with the number suffering, and dying, from pulmonary tuberculosis.[1] Means to prevent infection by tubercular milk are in our hands, if we choose to use them: no fresh legislation is required, and no fresh knowledge. The prevention of infection by tubercular dust is far more complicated; the problem may well appear insoluble to this generation, though it should not be so in the next. For this reason, the remaining chapters of this Section will deal mainly with the prevention, treatment, and after-care of pulmonary tuberculosis from the tuberculosis visitor's point of view.

Not only will most of the cases on her visiting list be those of pulmonary tuberculosis, but she can hope to play a larger part, both in prevention and after-care, than she can in non-pulmonary cases. The problems to be solved are less purely scientific in these cases, and therefore make much wider demands on the knowledge, love, and understanding of the visitor. In a later chapter the exact nature of this knowledge will be discussed. At this point, it is only necessary to emphasize the fact that pulmonary tuberculosis, more than any other disease, owes its present power and importance to four powerful allies: poverty, ignorance, drink and dirt. The tuberculosis visitor may, perhaps, be appalled when she realizes that she cannot hope for victory in the fight until these four enemies are laid low. She must, however, realize their importance, their origin, and the means of their defeat. As an eminent expert in tuberculosis once said: "Tuberculosis walks with poverty hand in hand, till they meet

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[1] In the City of Westminster, in 1919, the numbers were: Pulmonary tuberculosis, notifications, 319; deaths, 134. Other forms, notifications, 48; deaths, 21.

death round the corner." The tuberculosis visitor may well rejoice that there is less poverty due to the lowness or irregularity of wages than formerly. She will still find plenty of poverty due to accidents, to ill-health, or to the illness or death of the father of the family. She must know how best to advise in all these circumstances, and may be of real use if she refrains from giving anything more tangible than wise and helpful advice. If she can win the confidence of the father of the family as well as of the mother and children, she may actually be able to prevent that poverty which is sometimes caused by the father's not understanding how much of his increased wages should go to meet the constantly increasing expenses of the home.

The foe of ignorance is more strictly within the special province of the tuberculosis or health visitor. She must accept her responsibility as the teacher in the home —not the children's class teacher, nor the father's W.E.A. lecturer, but the mother's teacher—teaching without lesson-books, and only by invitation. It is comparatively useless to inveigh against the deficiencies of what is taught in the schools, or even to make a pother to become a teacher of child-care to children of twelve and thirteen : it is well worth while if, at the end of a year, or of two or three years, one mother has learned the value to a tubercular patient of abundant fresh air, of milk versus stout, of rest versus rush. [The health visitor will probably aim at teaching many other things besides, if she is also visiting in the cause of maternity and child welfare.] These are the lessons she will most need to teach in her share in the fight against tuberculosis, and the surest way to inform the minds of her hearers is to win their hearts first.

As with poverty, so with drink. The national solution of the problem lies far beyond the scope of any one health or tuberculosis visitor, who should, however, know enough of its causes and proposed cures to enable her to vote intelligently when the issue arises in an election. In

the solution of the problem in individual cases she may, as in that of poverty, give useful help. She may not be able to claim that she has reformed any confirmed drunkard: she may well suggest alternative methods of recreation to that of the public-house, but she can only do this if she knows when and where these alternatives are to be found. Further, by suggesting the use of non-alcoholic stimulants, such as strong coffee, she may help to provide attractive alternatives to alcoholic drink itself.

The problem of dirt, again, is a wide one. "Dirt is matter out of place." If there is not a place in which to put it, what then? The formation of dirt, and its transit into the houses of the people, are matters with which the health visitor is not directly concerned. The medical officer of health will no doubt press for the frequent scavenging, tar-spraying, and watering of the streets, and the construction of new streets having non-gritty surfaces. The provision of sanitary dust-bins, and the frequent removal of house-refuse are, again, not the direct concern of the health visitor (unless she holds a dual appointment as sanitary inspector), but these are all matters in which she should take a keen personal interest on behalf of her patients. It is little use to urge the sweeping of dust and dirt out of a house, even with tea-leaves, if it can only be deposited in an open brick ash-pit within three yards of the back door. Where cleanliness is unknown, frequent friendly visits—every care being taken by the health visitor to ensure that they are friendly—will probably do more to introduce cleanliness than any direct teaching on the subject. Also it is not difficult to show how the comfort of a sick person depends on cleanliness, and once cleanliness is introduced into one room of the house it may spread to others.

Enough has no doubt been said, in the early part of this chapter, to explain the importance of environment in relation to infection. Dust and dirt, conveying the tubercle bacillus in dried sputum, will assuredly produce,

and encourage the growth of the disease, whether at home or in the workshop.

The remarkable difference between the death-rates for pulmonary tuberculosis in men and women respectively in the City of Birmingham, as shown in Dr. Robertson's charts (see Appendix VIII (*b*)) is explained by the appallingly unhealthy conditions in which the majority of the men patients had worked. Being metal workers, there was a large amount of dust in the workshops, which both lodged in the lungs, impeding free breathing, and was also conveyed as dried sputum in the air. Further, the workshops were mostly built in small back-yards, consequently the amount of cubic space per man was relatively very small. Thirdly, being mostly situated in courts, and in the rear of other buildings, little or no sunshine shone in the workshops. Further, little or no attention was paid to the cleanliness of the workshops—not even to the prevention of spitting on the floor. Lastly, wages being low and public-houses being plentiful, all the four allies of tuberculosis—poverty, ignorance, drink and dirt—were present in full force. If we add to these considerations the fact that, having spent the day in such workshops, and the evening in equally airless public-houses, many of the workmen spent the night in bedrooms in "back-to-back" houses to which neither fresh air nor sunlight ever entered, the incidence of pulmonary tuberculosis among the men, as compared with the women, will appear less surprising. Though the women lived in the "back-to-backs," they spent a certain part of their time in the courts themselves, and very frequently worked in the kitchen or washhouse with the door wide open.

A comparison between these charts, and others showing the incidence between boys and girls respectively in Birmingham, and between men and women in other towns, proves that the nature of the environmental conditions, and not sex, is the determining factor.

(2) The Fight against Tuberculosis.

The campaign against tuberculosis is of comparatively recent origin. So long as the conviction was universally held that tuberculosis was, in all cases, a fatal disease, largely due to hereditary causes, and therefore both unpreventable and incurable, there appeared, indeed, little that could be done to combat it. As the suspicion grew that, besides being hereditary, the disease might also be infectious, a few special hospitals, such as the City of London Hospital for Consumption, the Brompton Hospital for Diseases of the Chest, and the Royal National Hospital for Consumption at Ventnor, were built and endowed, not, at first, from any hope of "curing" the patients, but as a means of lengthening the duration of the illness, on the one hand, and of providing some measure of isolation on the other. As a knowledge of the causes and growth of the disease has developed, so have the principles governing the selection of cases, and the methods of treatment. At the present time, all these special hospitals profess to undertake the treatment of early, and therefore presumably curable, cases only.[1]

As regards changes in methods of treatment, it is interesting to reflect that, within living memory, the windows in the wards of the City of London Hospital, Victoria Park, were kept firmly shut, in the supposed interests of the patients.

It may therefore be stated that, up till about 1905, the campaign against tuberculosis, both pulmonary and non-pulmonary, was entirely defensive : it was confined to treatment only, and was regarded, in the main, as a game played with death in which the dice were loaded against the patient. As research developed, however, and as the conviction grew that tuberculosis was both infectious, preventable, and, in a large measure, curable,

[1] The Royal National Hospital, at Ventnor, is indeed no longer a hospital, but a sanatorium.

the campaign took on a fresh aspect. It was no longer confined to defensive tactics against a strongly entrenched enemy, but was carried into the enemy's own recruiting areas. It became vigorously offensive, aiming at cutting off his reinforcements, and at isolating him entirely in the field. In other words, it was realized that, from a national, as well as from a broadly humanitarian point of view, it was useless to keep a few well marked cases in hospital for varying periods of time. What was needed was rather to inquire into the source of infection in each case, to dry up that source, and to examine every person who might have become infected from the same source. It then became clear that the preventive, or curative, treatment of all such "contacts" who showed any signs, definite or indefinite, of the disease, must be undertaken. It was also realized that the complete and permanent isolation of all intermediate and advanced cases, together with the best and most extended treatment and after-care of all early cases, must be essential measures if success was to be assured. Every person, medical or non-medical, in the country, who has devoted any personal study to this question, knows indeed that these are the only measures which promise to be in any way successful. In England, the first steps towards any large measure of improvement in the well-being of the community have always been taken by private individuals, combined in some form of "voluntary" effort. Our "voluntary" elementary schools and "voluntary" general hospitals are living witnesses to this fact, as are our "voluntary" dispensaries, hospitals, sanatoria, and farm colonies for the prevention, treatment, and after-care of tuberculosis. The first defensive measures—the provision of special hospitals for treatment—were taken by private enterprise. Similarly, visits to the homes of the patients, with some idea of ensuring a measure of comfort and after-care, was undertaken in some cases by private persons interested in the work of these hospitals. When the suspicion that the disease was infectious was crystallizing into a certainty, the voluntary

notification of the disease by medical practitioners followed. It is interesting to remember that the first institutions required to notify cases of pulmonary tuberculosis were Poor Law Infirmaries, within whose walls the greatest number of patients suffering from this "great white plague" are still to be found.

As these schemes directed by voluntary effort—whether in the direction of treatment, visiting, or notification—extended their scope, two things became clear: first, it was seen that the disease was so wide-spread that the problem of its prevention and treatment could not be solved by private enterprise alone, and, secondly, that some form of home treatment and home supervision of patients was required. The special provision for Sanatorium Benefit (which, in spite of its name, does not necessarily include treatment in a sanatorium) in the National Health Insurance Act of 1911, was the first partial recognition of the responsibility of the community for the treatment of tuberculosis. The opening of the Tuberculosis Dispensary at Edinburgh in 1888 was one of the first practical illustrations of what could and should be done by such institutions for patients for whom hospital or sanatorium treatment was either not required or not available. From this time onwards, both the "voluntary" hospitals and the rapidly increasing tuberculosis dispensaries, gave more and more attention to the prevention of the spread of the disease by the examination and "preventive treatment" of the children, and other contacts, of tubercular patients. The Tuberculosis Regulations of 1912, making the notification of tuberculosis, in any form, compulsorily notifiable by all medical practitioners, was the final and complete acknowledgment of the infectious nature of the disease. By implication, it was a further step towards the recognition of the responsibility of the community for prevention, treatment and after-care. Full responsibility for treatment and after-care has been definitely assumed, as regards members of H.M. Forces, by the provisions of the Circular issued in

December, 1918. The duties laid upon local authorities by this circular had, however, already been assumed on behalf of all notified persons by those local authorities who had adopted an enlightened policy in the matter.[1]

At the present time, every person notified to be suffering from tuberculosis is visited, on behalf of the community by the tuberculosis medical officer, or by the tuberculosis health visitor, of the local authority of the area in which he or she is living. The purposes of this visit will be more fully explained in the next chapter. Its utility will depend partly on the personality, training, and experience of the visitor, partly on the attitude of the patient and the patient's family. It will also depend largely on the opportunities of treatment available, and on the environmental conditions of the patient, whether at home, at school, or at work. At present it is impossible to maintain that the provision by the community of opportunities of treatment—whether at dispensaries, in hospitals, or in sanatoria—is anything but hopelessly inadequate. The responsibility of the community for the environmental conditions of the home, of the school, and of the workshop is, in theory, recognized for all persons under the provisions of the Public Health, Housing, Education, and Factory and Workshops Acts. If these Acts were adequately and boldly administered, there would be far less need for special provisions for tubercular persons, whether in hospitals, sanatoria, "tuberculosis houses,"[2] or "open-air" schools. Our watchword must be "Educate, Educate, Educate," until tuberculosis is as extinct in Britain as the "Black Death." In the words of Canon Temple, spoken at the annual meeting of the Workers' Educational Association at

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[1] In the City of Westminster, no additional staff, and no addition to the duties of the existing staff, beyond the keeping of a separate index, was required.

[2] A few "tuberculosis houses" are included in the new housing scheme of one of the large Midland towns.

Nottingham, in 1919: "In relation with the time, our achievement is immense; in relation with the task, our achievement is negligible."

(3) The Part of the Tuberculosis Visitor in the Fight.

(*a*) *Introductory.*—From the early days of the campaign it was realized that some measure of home visiting, as distinct from nursing, was advisable for patients discharged from hospitals for consumption. This visiting was undertaken, at first, by Ladies' Visiting Committees, who afterwards first saw the patients in the wards, and visited them in their own homes. At a later date, most of the London chest hospitals appointed Lady Almoners, who became responsible for this work. Similarly, other voluntary organizations, such as the Charity Organisation Society, began to realize the importance of ill-health as a factor in poverty, and appointed "Health Committees," to which voluntary health visitors were attached. From these committees there developed in some places, such as Westminster and Battersea, voluntary Health Societies, working both through salaried health visitors and through volunteers. At the time of the Tuberculosis Regulations of 1912, which threw the duty of home visiting of all notified persons on the local authorities, there might already be, in some cases, three persons visiting in the home of the tubercular patient: the "lady from the hospital," the "lady from the organisation," and the "inspector," i.e., the man or woman sanitary inspector from the Public Health Department. In 1912 it became the duty of the local authority in every area to appoint one or more tuberculosis visitors to visit all notified persons on its behalf. In some cases either the medical officer of health, the tuberculosis officer, the sanitary inspector, or the health visitor appointed under the Notification of Births Act undertook "tuberculosis visiting." In other places special tuberculosis visitors were appointed.

The co-ordination of the existing voluntary effort and

of the newly established communal effort thus established required, in some places, clearer thinking and more delicate handling than it received. It is essential that some mutually satisfactory arrangement should be made, where this does not already exist, between the visitors appointed by voluntary bodies and those appointed by local authorities, otherwise some patients may be over-visited while others are rarely visited at all. It must never be forgotten that the only person having statutory authority for visiting is the tuberculosis visitor of the local authority. If the duty of visiting under the tuberculosis regulations is delegated to any other person, this must be done by the local authority itself. Similarly, it must not be forgotten that the immediate object of all visiting is the well-being of the patient and his or her family, and that, if a "voluntary"[1] visitor has become the friend of any particular family, she may be better able to ensure this well-being than a comparative stranger. In practice, a fairly satisfactory arrangement is for the tuberculosis visitor to visit all cases on notification, in order to obtain the information required by the medical officer of health for statistical purposes, and then to arrange for periodic revisits and reports by "voluntary" visitors in all cases already known to them, or necessarily coming under their notice. It must be provided, naturally, that the visits and reports of such visitors are likely to be of value to, and accepted by, the tuberculosis medical officer.

The part played by the tuberculosis visitor in the fight is, in actual practice, concerned with the personal problems of a number of individual persons and families. Her work is essentially that of a teacher and a friend : it is not, and should not be, that of a nurse. In some districts it may be necessary, as a temporary expedient, to appoint district nurses as tuberculosis visitors, but nursing is not the work of a tuberculosis visitor. She should, indeed,

[1] "Voluntary" visitor—a visitor appointed by a "voluntary" body, not necessarily an unpaid visitor.

acting on the advice of the tuberculosis officer, aim at the removal of all cases requiring nursing from their homes into suitable institutions—somewhat a counsel of perfection, owing to the absence of such institutions in many districts, but attainable in some. The removal of such cases, usually of the advanced type, is desirable, not only in the interest of the patient, but still more in that of his family. Where there are no children or young people in the house, and the patient can be kept comfortable and happy at home, occupying an airy room, properly fed and nursed by a district nurse, there is no particular reason for pressing for his or her removal to an institution. The tuberculosis visitor should however arrange for the periodic examination, by the tuberculosis officer, of the relative or neighbour who attends to the patient, as well as for the disinfection of the room and its contents after the removal or death of the patient.

In the absence of compulsory powers for the removal of patients, the tuberculosis visitor will only be able to ensure that the advice of the tuberculosis medical officer with regard to institutional treatment (assuming that it is available) is followed, by methods of peaceful persuasion. To be successful, this persuasion will depend chiefly on two considerations: on what is said, and on how it is said. The tuberculosis visitor must always remember that no patient, unless he or she is mentally defective, is so stupid as not to be able to understand something of the nature of the disease, and of the method and danger of infection. The more intelligent the patient, the better will he or she understand, and the more ready will he or she be to act on the advice given. There may be flat denial in some cases—denial that the patient is suffering from tuberculosis at all, denial that the disease is infectious, denial that any cure is possible, denial that any examination of contacts is necessary—but in many more there will be a marked willingness to learn. Patients and their families are, as a rule, willing to co-operate in their own treatment, in the prevention of fresh cases in their

midst, and in their own after-care. Their willingness to do this will depend largely on the teaching capacity of the health visitor, and of her power to convince others that having learnt, they must act. Ability on the part of patients to repeat a well learned lesson is not a proof of successful teaching in a health visitor : the number of patients who have actually acted, to the limit of their opportunity, on the advice given by the tuberculosis medical officer is the best indication of success.

It follows, therefore, that the tuberculosis visitor must first acquire some knowledge of the disease herself, and also possess the ability to impart it. For this reason the training of a tuberculosis visitor, like that of all health visitors, should include some knowledge of psychology, and of teaching methods. Still more important is the ability to convince patients and their friends that the whole business—whether prevention, treatment, or after-care—is really worth while, that it matters enormously whether or not this foul disease wins or is beaten. And, in order to convince, the health visitor must be convinced herself first. That is why it is no use entering the public health service unless it is with a sense of vocation in the service of public health.

Having this sense of vocation, the next essential, after knowledge, and the ability to impart it, is personal sympathy, developing readily into personal affection. The health visitor must be able to convince both patients and their friends that it matters to her, personally, whether or not advice is followed, not merely from a professional point of view, but because they are her personal friends. And she will never produce this conviction unless it is based on reality. She must have a real personal liking for the men, women and children under her care before she can hope that they will be convinced by her arguments.

(*b*) *What a Tuberculosis Visitor ought to know.*—Human motives are highly complicated in the more highly developed intelligences. The motive of love is a very

simple one, and the most effective. There are, therefore, three branches of knowledge which should come within the ken of a tuberculosis visitor. First, technical knowledge. She must know something of human anatomy and physiology, in order to understand the cause and development of the disease. She must also know some, thing of hygiene and sanitation, especially of the provisions of the Public Health, Housing and other Acts having a direct bearing on her work.

Secondly, she must know something of the social conditions in which the majority of our countrymen live. She must know the rates of wages for various kinds of work prevailing in the district in which she works, the rents paid for certain types of houses, the various forms of public and private provision for supplementing wages in case of illness or accident (National Health Insurance Act, Workers' Compensation Act, Guild of Help, Charity Organisation Society, Poor Law Relief, &c.). She must also know the exact steps to be taken towards obtaining any form of treatment advised by the tuberculosis medical officer. She must know, for instance, exactly which forms must be filled up before hospital or sanatorium treatment can be obtained. She should know the length of the waiting list for any particular institution. She must know what provision there is, if any, for preventive treatment, such as open-air schools, and "boarding out," and what forms of employment are both desirable and obtainable for cases discharged from sanatoria as "fit for light work."

Thirdly, and finally, she must possess a wide and intimate knowledge of men, women and children—a knowledge which will have taught her that personal sympathy, showing itself in the readiness to take infinite personal trouble for each and all of her patients, is the master-key to success. The same arguments will not appeal to say, a civil service clerk as to a costermonger's wife, but both patients will agree to undergo the prescribed treatment, once convinced that it is a matter of personal

interest to the health visitor. As regards children, surely the way to their hearts is not difficult to find? It lies along the path of individual attention and understanding; the first step is to learn and remember each one's name. (Incidentally, a genuine interest in and love for the children is often the quickest way to win the confidence of their fathers and mothers. A man or woman will often refuse treatment on his or her own account, but, will finally submit to it, if convinced that it is the only means of preventing the disease from appearing in the children.) The health visitor need have no fear of "undermining parental responsibility" by her own love for, and care of, the children. Where the sense of such responsibility appears to be, in some measure, lacking, it is often revived by the interest of such a friend of the family—especially in the case of an unattractive child.

To sum up, the tuberculosis visitor ought to know something of personal and public health, of social conditions and of human nature, whether in men, women, or children.

(*c*) *What a Tuberculosis Visitor ought to do.*—Knowing this, what ought she to do? She will, presumably, work under the direction of a tuberculosis medical officer, who will be responsible for the treatment given at the tuberculosis dispensary, and for the selection of patients in attendance there for other forms of treatment. She will help the tuberculosis medical officer in every branch of his work, in prevention, treatment, and after-care.

As regards prevention, her work will lie chiefly in the families of tubercular patients. She will aim at securing the separate sleeping accommodation for the patient, or at least a separate bed under an open window. As regards the examination of the other members of the family, she will be guided by the instructions of the tuberculosis medical officer. Whenever possible, the medical officer will, no doubt, arrange to examine every member of the family, either at home, in school, or at the dispensary. The work of the tuberculosis visitor will be to make the

detailed arrangements for the examinations, so that the "contacts" are ready at the appointed time and place, their temperature and pulse taken, and everything required by the doctor, such as hot water, towel and soap, are also ready. Where the examination of all contacts is not possible, the medical officer will probably leave the selection of contacts to the discretion of the tuberculosis visitor, and, in this case, frequent visits for the purpose will be necessary. Contacts, especially children, may show no symptoms at all at one time, and have clear signs of the disease if examined a few months later.[1]

The success, or otherwise, of this preventive work will depend very largely upon the tuberculosis visitor, especially as regards the children. Mothers hardly ever realize the importance of the examination, by an expert, of children who, to them, appear "quite all right," or merely suffering from "a bit of a cold." Much time will be saved, in some cases, if the tuberculosis visitor, on paying the first visit on the notification of say, the father or mother, remarks pleasantly: "Well, I suppose you would have no objection to the doctor's examining the children, if he wants to?" The mother, not having considered the matter at all, has no objection ready, and all that is necessary is to make a provisional appointment for the examination on the spot.

With regard to treatment, the work of the tuberculosis visitor in any particular district, will depend largely on the organization of the work of the local tuberculosis dispensary. In some places, the visiting of patients attending the dispensary is done by the nurses attached to the dispensary. In such places, the tuberculosis visitor appointed by the local authority will have little or nothing to do with treatment. In other places, as in the City of Westminster, each tuberculosis health visitor attends at

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[1] In the case of an Italian family in Soho, a son of a tubercular father was examined in March, and found to be perfectly sound. This boy died from pulmonary tuberculosis in the following September.

the tuberculosis dispensary during the sessions allotted to the patients in her particular district. She helps the doctor in the consulting room, taking his clinical notes, and giving him any information he may require as to the home conditions of the patient and his family.[1] In this case, the dispensary nurse is fully occupied in taking weights, temperatures, pulses, &c., in the waiting room.

In after-care, the tuberculosis visitor plays a still more important part, environmental conditions being all-important, and treatment being, as a rule, no longer necessary.

Assuming that, prior to the patient's admission to sanatorium, the visitor had already become the friend of the family, it will naturally be to her that the patient and his family will turn, if help is needed towards finding the kind of work, and the kind of house, advised by the tuberculosis officer. (The question as to whether the tuberculosis medical officer or the sanatorium medical officer is the proper person to give advice in these matters is outside the province of the health visitor.) It is in this part of the work that a knowledge of social conditions is essential, as well as the power to interest well-disposed and well-to-do people in the neighbourhood. No serious attempt has yet been made, by the community, to solve the problem of the after-care of patients, whether insured or uninsured, discharged from sanatoria.

Broadly speaking these may be classified into three grades. There are the Grade A cases—those who, given suitable home conditions, may safely return to their former full-time occupations. In these cases, the tuberculosis visitor must make every possible effort to ensure

[1] By such an arrangement, the tuberculosis visitor learns, at first hand, what treatment has actually been advised in each case, and whether the medical officer is satisfied with the patient's progress, or not. If the medical officer thinks it advisable, she will also have excellent opportunities of learning more of the peculiarities of the disease, and of its various forms. From the doctor's point of view, much time is saved by this method.

that proper arrangements are made for separate and adequate sleep, and suitable and adequate food. Strange as it may seem, it is often in these cases that it is most difficult to convince the patient, or his wife, that special precautions are necessary. They are so gratified at the immense improvement in the condition of the patient, so convinced that the "cure" is permanent, and so sure that there is no further risk of infection, that the tuberculosis visitor must often appear to them as a sad kill-joy when she urges, for instance, the continued use by the patient of his own separate eating utensils. The risk of a temporary unpopularity is, however, one of the many which must be faced by the tuberculosis visitor who considers that her work is worth doing.

In Grade B are the cases who may safely undertake a full-time "healthy" occupation, that is, work not involving any great or sudden exertion, and carried on, either out of doors, or in an exceptionally healthy indoor environment. Work of this kind is not easy to find for those whose work before treatment has been of a less "healthy" nature. One of the most successful pieces of after-care work in a case of this kind falling within the personal experience of the writer, consisted in transforming an ex-chef at a West End London club into a park-keeper in the service of the London County Council. Though the home environment was far from ideal, and though the disease was well marked, the patient was able to work absolutely regularly for a number of years. In this case, as in all others, whether involving after-care or not, the work of the tuberculosis visitor included the arrangements for the examination of the patient's wife and children, and advising as to the best use of the existing accommodation for sleeping purposes (other accommodation being unobtainable). It included also periodic revisits in order to inquire as to the progress of the patient, to advise as to the work most suitable for the children on leaving school, and to remind the patient when he was due for periodical re-examination

at the tuberculosis dispensary. In this case, none of the family showed any definite signs of tuberculosis, and the eldest boy, on leaving school, entered the service of a fishmonger. As this work was carried on largely in the open air, as there was a good prospect of learning the business, and as, moreover, the boy himself was anxious to undertake the work, conditions were favourable to his continued freedom from tubercular infection. At the time of writing, he is still well, and still working at the same shop.

In Grade C cases, it is still more difficult to arrange for satisfactory after-care: For patients in this grade full-time work of any kind is impossible, at any rate for some time after leaving the sanatorium. Any attempt to undertake work for more than, say, four hours a day, only ends in a fresh breakdown. It is, however, none the less necessary that they should work for a certain number of hours each day, in the interest of their health, of their morals, and of their finances. Suitable part-time employment is almost impossible to find, either for men or women. For men and boys, the kind of work likely to be offered is that of a boot-boy or handyman for the mornings, possessing the double disadvantage of an early morning start and the carrying of heavy weights, such as coals. For women and girls, the most usual form of part-time work offered is either heavy household scrubbing, the washing of clothes, or the care of young children—how many times has one been told with obvious satisfaction by the mother of a tubercular girl of 16 or 17: "I've got just the right kind of work for Milly now, Miss. She goes to a lady every afternoon and takes the children out." In one case, the children were the girl's own baby brothers, one of whom died from tubercular meningitis shortly before his sister went to a sanatorium. The notification of the baby's death, and of pulmonary tuberculosis in the older sister, were received in the same week. After her discharge from sanatorium, the after-care of this girl was complicated by the fact that the

parents were the managers of a public-house, and that Emily was expected to help with the early morning cleaning in the bar, and to look after the younger children later in the day. The two hopeful factors in the case were that there was no dearth of food, and that Emily had a separate bedroom. One could only urge the freest possible ventilation of the bar during cleaning time, and that Emily's duties with the children should be strictly confined to taking them out in the park—also, that she should continue to attend regularly at the tuberculosis dispensary for supervision.

Where, however, the patient is the principal wage-earner, the provision of adequate food and house-room in return for part-time work is economically impossible. Isolated attempts to solve the problem on a large scale has been made, one of them by a far-sighted trade union in a provincial town. In this case the patient undertakes to consult the tuberculosis officer regularly, and to work for the daily number of hours advised by him. In return, the difference between the wages actually earned in the hours worked, and the wages which would be earned in a full week's work, is made up from a special fund formed for this purpose by the trade union. In many cases, it is found that a patient beginning, on discharge from the sanatorium, with four hours work a day, is capable, at the end of say, three months, of doing six, and possibly at the end of six months, of doing the full eight. By that time he will again be self-supporting. In the absence of such a scheme he would probably become a hopeless invalid, and a drag on the club funds for the remainder of his life, a complete breakdown being the result of an attempt to work for eight hours a day immediately on his return home. If some such system as this could be more widely adopted, the task of the tuberculosis visitor in connection with after-care would be an easier and more hopeful one than it is at present. The tuberculosis care committees set up by the various local authorities in London are of little practical use for

dealing with Grade C cases, as they have no funds at their disposal.

(*d*) *"Don'ts" for the Tuberculosis Visitor.*—However much one may object to the first part of the title, "tuberculosis visitor" (and it is somewhat of a shock to be introduced to a patient's friend in the words : "You needn't go, Mrs. Reilly, this is the tuberculossis" [sic]), one can only rejoice that one is described as a visitor, though an uninvited visitor. The first visit to a family should be, as far as possible, in the nature of a first call to new comers of one's own social standing. From one point of view, the object of the visit is to obtain a large amount of detailed information for official purposes [see Appendix B, City of Westminster tuberculosis visitor's record card], but this is not the aspect of the visit which should be presented to the patient. It is a good rule never to ask to go inside any house—if one begins by explaining that Dr. Smith (the doctor notifying the case) has written to Dr. Brown (the medical officer of health) about the patient, and that Dr. Brown has asked one to call, to see if one can help in any way, the invitation to "come inside a minute" is not likely to be long delayed. One is then the invited guest, not the intruding official, and, as such, one must be careful to show nothing but friendly interest and a willingness and ability to help the patient and his family by advice. Once having made the patient (or the member of the family with whom one is conversing) realize this, there will be no difficulty in obtaining practically all the information required on the somewhat alarming official card, without putting any string of questions. Even such intimate details as wages and rent can often be obtained by turning the conversation on to the patient's diet, and the desirability of, say, a quart of milk a day. One is not a worse, but a better official, if one carefully conceals one's official notebook until safely out of sight of the house.

It is, moreover, excellent memory training for the visitor. To produce a notebook or record card while

actually conversing with the patient is certain to dry up the spontaneous flow of relevant and irrelevant details which are a source of invaluable information to the visitor. To produce a notebook, in some quarters, may even suggest the policeman's formula: "Anything that you say now may be used in evidence against you." In short, "don't" forget you are a visitor and therefore a guest: "don't" be official.

Similarly, don't use long words. Long words may sometimes impress people to whom they are not familiar, but usually impress unfavourably. For instance, to begin an acquaintance by saying: "I have called to see you under the Notification of Tuberculosis Regulations," would not be likely to result in a cordial invitation to come inside a house. Similarly, a statement that separate sleeping accommodation is desirable because "tubercle bacilli are freely exhaled in the breath of infected persons" is not likely to convince an overworked mother that it is really worth while to make up a bed for George in the parlour, and thus "spoil her front room." This may seem the most elementary common sense, but it is none the less a necessary "don't" to some health visitors fresh from the examination room.

This "don't" leads naturally to another. It is true that, to most of one's patients, the use of long words is both tactless and useless. On the other hand, patients who have been under treatment in a sanatorium in which the treatment included good lectures from the resident medical officer, will be familiar with most of the commoner technical terms. Similarly, some of the more intelligent may have asked why "the lady from the Town Hall" should call on him [it is a great help if panel doctors warn patients beforehand that the visitor is likely to call]. In these cases to refrain from the use of long words is as tactless as it is to use them in others. The only safe guide is another "don't": "don't" forget that each patient is a person, as well as a case. The exact condition of his lungs constitutes him a case, but the lungs are not the whole man.

To those whose training has wisely included social—as distinct from medical—work, there is another danger, the danger of regarding each patient and his family as a "case" needing public or private assistance. Although it is, unfortunately, true that the presence of tuberculosis in a family necessarily reduces their economic resources, it is none the less true that, in the large majority of cases, the community and not the individual family is responsible for the introduction and growth of the disease. Also, to a limited extent, the community has recognized this responsibility, and provides, however inadequately, for the maintenance and treatment of the infected person. It is therefore most important not to regard tubercular patients as "applicants" for relief, any more than patients suffering from small-pox, measles, or scarlet fever are so regarded. In compiling annual returns or statistical tables of any kind, one must think in "cases": at all other times "don't."

In common with other public health officials at the present time, the tuberculosis visitor will find that it is impossible to cope adequately with the volume of work laid upon her by official instructions. She will constantly be faced with the choice of letting either the office work or the visiting fall into arrears, or between letting the routine revisits become long over-due and keeping the more difficult mothers of "suspect" children up to the mark in the matter of regular dispensary attendance. Until the number of tuberculosis visitors and their assistants is greatly increased, these problems are likely to continue. In many cases, the provision of a shorthand typist for transcribing records of visits, for correspondence, and to undertake indexing, &c., would greatly facilitate matters, as the tuberculosis visitor could then give more time to visiting. Whatever the position, however, there are two "dont's" which are essential when one feels "snowed under" by the work. First, don't overwork—however repugnant the advice may seem, remember to "down tools" at the specified time. Occasionally,

evening visits may be necessary (though dinner hour visits can almost always be substituted), but neither evening visits nor evening office work should be anything but the rarest exceptions. Remember, a tired visitor is never a good visitor—she cannot give out to her patients what has previously been exhausted—vitality and energy. Overwork must end in exhaustion of some kind—of strength or nerves or temper—and so it defeats its own ends. Also, don't hurry—or don't appear to hurry—when visiting. [In the dispensary, it will probably be essential, but then it must be done without hurrying the patients.] To cut short a long stream of confidences may enable one to "get two more visits in before lunch," but it may so deeply offend the speaker that many more visits will be required before that patient's confidence is regained—if at all. And, unless one keeps the confidence of one's friends the patients, one's work is useless.

Finally, don't despair. Over and over again, one is asked: "Don't you find the work very depressing?" and one's answer is "No." The work is enormously interesting, it is unendingly varied, it is intensely individual. Also, though the results in "well-marked" cases, under existing conditions, are often unsatisfactory, the preventive side of the work—the children's side—is hopeful and cheering. One has to dwell on the evil that "might have been" rather than on the evil that it is beyond one's power to remove, to get the most hopeful impression of one's work. Nevertheless, there is reason to rejoice in the gradual growth of a right understanding of the problems to be solved. There is also reason to rejoice in the personal affection of individuals which the work brings with it. If one does not look for "grateful patients," one finds friends.

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APPENDIX I.

Women Sanitary Inspectors' and Health Visitors' Association.

(Registered as a Trade Union), affiliated with N.A.L.G.O.

Address: 1, *Upper Montague Street, Russell Square, London, W.C.* 1.

Objects.—The Association is established to safeguard the interests and improve the status of women sanitary inspectors and health visitors and to promote the interchange of such knowledge of sanitary and social science as is likely to be of assistance to them and others.

Women sanitary inspectors duly appointed by a sanitary authority, health visitors, superintendents of maternity and child welfare centres, and tuberculosis visitors duly appointed by a local authority, are eligible for membership.

Women holding certificates recognized by the Ministry of Health for sanitary inspectors, or women holding certificates granted by a recognized Training Centre for health visitors, but without official appointments, may be elected as associates.

All health visitors are advised to join this Association as it is the only one which devotes itself entirely to the interests of Public Health workers and includes as members or associates, *all* women engaged in health visiting whether official or voluntary.

It has been successful in many instances in getting salaries raised where they fell below a certain standard, and it has also enabled its members to get represented on practically all societies of any influence affecting health visitors' work.

It has recently adopted the following scale of salaries which is the scale approved and adopted by the men Sanitary Inspectors' Association.

Assistant Women Inspectors or Assistant Health Visitors.—£250 rising by ten annual increments of £10 to £350.

Women Sanitary Inspectors, Women Inspectors of Nuisances or Health Visitors.—£350 minimum rising by ten annual increments of £15 to £500.

Chief Women Inspectors or Chief Health Visitors.—£500 minimum.

APPENDIX II. (A).

LIST OF INSTITUTIONS RECOGNIZED BY THE BOARD OF EDUCATION UNDER THEIR REGULATIONS FOR THE TRAINING OF HEALTH VISITORS.

	Name of Institution	Name and address of the person to whom inquiries should be addressed
A 1	King's College for Women, University of London	Miss F. Robinson, King's College for Women, Campden Hill Road, London, W. 8.
B 2	Battersea Polytechnic ...	The Principal, Battersea Polytechnic, London, S.W. 11.
C 3	Bedford College for Women, University of London	The Principal, Bedford College for Women, Regent's Park, N.W. 1.
D 4	University College of South Wales and Monmouth	The Registrar, University College Registry, Cardiff.
E 5	Liverpool School of Hygiene	Dr. E. W. Hope, 126 and 128, Mount Pleasant, Liverpool.

INSTITUTIONS RECOGNIZED BY THE BOARD OF EDUCATION.

A.—*King's College for Women, Campden Hill Road, W. 8.*

Length of Training.—One or two years.

Fees.—30 guineas per annum, or 11 guineas a term for the first year, 15 guineas for the second year.

Examining Body.—King's College, with external examiners for final exam.

Examination Fees.—

Hostels.—70 to 80 guineas per annum.

First Year.

(1) *A short course in Introductory Science*, such as will serve sufficiently to acquaint the students with the laws of Nature in order to enable them to understand their study of the functions of life.

(2) *A Study of the Functions of Life.*—This course is designed to instruct the student as to the structure and functions of the cell, both as a vital unit and when aggregated to form groups or systems.

(3) *Household Science.*—A short course will be arranged so as to teach the students the needs of a working-class family as to food (cookery and household budgets), and the methods required to ensure cleanliness.

First and Second Years.

(4) *Hygiene.*—Lectures in personal and domestic hygiene, including minor injuries and ailments; in general and municipal hygiene, and in infant and child hygiene.

(5) *Lectures in Sanitary Law, and Building Construction* will cover the requirements of the Sanitary Inspectors' certificate, which includes practical instruction and excursions in connection with the subject of the lectures.

Practical work among infants or at hospitals, or among school children will be arranged for each candidate according to individual requirements. Arrangements will also be made for those wishing to take courses of study for work among mentally defective children, or for work among those suffering from tuberculosis.

General time tables will be available during the summer term for the coming session.

There will be a few bursaries available, not exceeding 10 guineas per annum, for suitable candidates towards the cost of tutorial fees for those who cannot afford the full fee.

B.—*Battersea Polytechnic, London, S.W.* 11.

(Full syllabus can be obtained, price 2d.).

Length of Training.—One or two years.

Fees.—£5 per term, or £14 per annum.

Examining Body. — Battersea Polytechnic Examination Board with representatives from the Board of Education.

Examination Fees.—£2 2s. at present, probably £3 3s. in future.

Hostels.—£13 15s. to £19 15s. per term.

The fees include full board (i.e., breakfast, mid-day lunch, tea and dinner) on Saturdays and Sundays, and breakfast and dinner on the remaining five days of the week. Each student must bring bed-linen, rug or eider-down quilt, soap, toilet towels and table napkins.

Other Expenses.—Travelling expenses when doing practical work and visiting places of interest; books, &c.

Training.—Theoretical.

(1) General elementary science.
(2) Elementary physiology.
(3) Hygiene and public health.
(4) Maternity, infant and child care.
(5) Simple first-aid and home nursing.
(6) Local Government.
(7) Law relating to public health.
(8) Law relating to the protection of women and children and young persons.
(9) Social science and economics.
(10) Meat and food inspection.

Practical.

(1) *Experience at Child and Infant Welfare Centres.*—During *first year*, one, or one and a half days a week. During the *second year* the following training will be arranged:—

Experience at Child and Infant Welfare Centres four afternoons a week for two months.

(2) *Practical Social Training.*—Students will attend an office of the Charity Organisation Society on four days a week for two months.*

(3) *Maternity Work.*—Arrangements have been made for students to do maternity nursing on the district every morning for six weeks, and to have two afternoons a week at the Lying-in-Hospital.

(4) *Tuberculosis Dispensary.*—Attendance at a tuberculosis dispensary will be arranged.*

(5) *Children's Observation Wards.*—Students will attend as daily probationers for a period of two months. Attendance will usually be from 7.30 a.m. to 12.30, or 1 p.m.*

(6) *Household Management and Practical Cookery.*

(7) *Cutting out and making Infants' Garments.*

(8) *Practice in giving health talks to mothers.*

(9) *Visits to Places of Interest.*—Day nurseries, open air schools, hospitals, disinfecting and cleansing stations, water works, &c.

C.—*Bedford College for Women, Regent's Park, N.W.*1.

Length of Training.—One or two years.
Fees, 20 guineas per session. Registration fee 10s.
Examining Body.—
Examination Fees.—
Residence or Hostel.—77 to 83 guineas per session.

Academic Courses.

(1) Elementary Physiology.

(2) Elementary Economics and Social Problems.

(3) Hygiene (including infectious and communicable diseases, infant and child welfare).

(4) Artisan Cookery and Household Management.

(5) Supplementary lectures on Maternity and Child Welfare and on Tuberculosis Dispensaries (in connection with the Practical Work).

Practical Work.—During the first year the practical work will be devoted to Practical Physiology in the College Laboratories, general social conditions in connection with various social agencies, Care Committee work—especially on the medical side—and Tuberculosis Dispensaries.

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* Students will attend for lectures at the Polytechnic on two half-days a week during practical training.

During the second year, at least three months full time work must be spent at an Infant Welfare Centre and six to eight weeks at a day nursery and observation ward for ailing children. Visits of observation are arranged in connection with the hygiene course.

D.—*Universtiy College of South Wales and Monmouthshire, Cardiff.*

Length of Training.—Two years or as determined by the Interviewing Committee.

Fees.—£15 per session (including Registration Fee).

Examining Body.—

Examination Fee.—£3 3s.

First Year.

Theoretical instruction :—

(1) Development and growth. } 1st term.
(2) Reproduction. }

(3) Digestion. } 2nd term.
(4) The Skin. }

(5) Special senses. } 3rd term.
(6) The Circulation. }

Theoretical instruction and demonstrations take place in the afternoon of each day.

Practical work.—At King Edward VII's Hospital—in rotation.

(*a*) Out-patient department. }
(*b*) Wards. } Part time for three terms.
(*c*) Maternity department. }

Also—

(i) At a fever hospital, *or*
(ii) At a tuberculosis hospital or sanatorium, *or* } Whole-time for one term.
(iii) At a factory welfare department.

Second Year.

Theoretical instruction :—

(1) Respiration. } 1st term.
(2) Excretion. }

(3) The muscular neural system. 2nd term.

(4) Methods of giving simple health instruction. 3rd term.

Demonstrations and theoretical instruction take place on Saturday morning and Monday morning and afternoon of each week.

Practical work.—In rotation at

(*a*) Maternity and Infant Clinics.	All day
(*b*) School Clinics.	Tues., Wed.,
(*c*) Training School of Domestic Arts.	Thurs. and Fri.

Home visiting in connection with (*a*) and (*b*).

E.—*University of Liverpool.*

Length of Training.—One or two years.

Fees.—£15 15s. for full course, £10 10s. for shortened course.

Examining Body.—Liverpool Sanitary Science Instruction Committee (Liverpool University).

Examination Fee.—

Training—Theoretical.

(1) General structure and physiology of the body.
(2) Methods of artizan cookery and household management.
(3) General hygiene of the dwelling.
(4) Health of working girls.
(5) Foods.
(6) Infectious and Communicable Diseases.
(7) Maternity, infant and child welfare.
(8) Economics and social problems.

Practical.

The practical work will consist of attendance and work on at least three days a week at the various institutions dealing with maternity and child welfare, such as infants' and children's hospitals, day nurseries, babies' homes, ante-natal and infant clinics.

A part of this work may be taken concurrently with the systematic course of lectures, but at least nine months must be devoted to the practical training.

TRAINING INSTITUTIONS NOT RECOGNIZED UNDER THE NEW REGULATIONS.

Place of training	Length of training	Theoretical or practical	Fees	Examining body	Exam. fees
National Health Society, 53, Berners Street, Oxford Street, W. 1	H.V., 9 months	T. ...	£25 ...	National Health Society	
	S.I., 3 months	T. ...	£16 16s. Composite fee, £30	S.I.E.B.	£3 3s.
Royal Sanitary Institute, 90, Buckingham Palace Road, S.W. 1	H.V., 3 months approx.	T., with attendance at Infant Welfare Centres	£5 5s. ...	R.S.I.	£4 4s.
	M. and C.W., 3 months approx.		£5 5s. ...	R.S.I.	£4 4s.
	S.I., 3 months approx.		£5 5s.	R.S.I. S.I.E.B.	£4 4s. £3 3s.
Sheffield Central Secondary Evening School	7 months approx.	T. ...	10s. 6d. ...	R.S.I.	£4 4s.
City of Birmingham Municipal Technical School	H.V., 34 weeks approx.	T. ...	10s. ...	R.S.I.	£4 4s.
	M. and C.W., 26 weeks approx.	T. ...	£2 ...	R.S.I.	£4 4s.
	S.I., 35 weeks approx.	T. ...	£3 ...	R.S.I. and S.I.E.B.	£4 4s. and £3 3s.
St. Helens Municipal Technical School	H.V., not stated	T. ...	£1 ...	R.S.I.	£4 4s.
Bristol University Settlement	H.V., 2—2½ years	T. and P.	£75, including exam. fees, board and residence and coaching fees	R.S.I.	—
Liverpool Ladies Sanitary Association (Nursery Training College)	3—6 months	P. and preliminary T.	Resident, £10—£50; non-resident, 10s. 6d.—£1 1s. per week	Liverpool L.S. Association	—
Leeds Central Technical School	7 months approx.	T. ...	£1 1s. ...	R.S.I.	£4 4s.

S.I. Sanitary Inspector.
H.V. Health Visitor.
M. and C.W. Maternity and Child Welfare.
R.S.I. Royal Sanitary Institute.
S.I.E.B. Sanitary Inspectors Examination Board.

APPENDIX II. (B).

Board of Education, Regulations for the Training of Health Visitors.

Prefatory Memorandum.

(1) The experience of the last few years has made it evident that the efficient discharge of many of the powers and duties of Local Sanitary Authorities and of Local Education Authorities for promoting the health of the population, and especially of children, depends in a large measure upon the existence of an adequate supply of women qualified effectively to undertake home visiting and other responsible functions in connection with Maternity and Child Welfare work, the School Medical Service and other local health activities.

(2) No doubt, as with other professions, personality and enthusiasm are essentials of success, but in themselves they do not suffice. There is at least an equal need for practice to be based upon a firm body of knowledge. Recently much has been done by the establishment of courses of lectures and of examinations to raise the standard, but it is now generally recognized that the profession of a health visitor has become sufficiently permanent to justify a further advance and to make it reasonable to expect that persons undertaking this kind of work should first undergo a special course of training. It is fully recognized that the three years' training necessary for a fully qualified hospital nurse or the training for the Certificate of the Central Midwives Board is of value to a health visitor, but these courses do not cover many of the functions which a health visitor may be expected to perform.

(3) The Board understand that the Ministry of Health have decided to lay down the general principle that all persons hereafter to be recognizsd as health visitors should have been through a special course of training approved for the purpose. They recognize that existing health visitors cannot reasonably be required to undergo training, though a number may be desirous of doing so and may properly be granted facilities for the purpose by their Authorities. On the other hand, in the case of *future entrants* to the profession, while some time must elapse before the requisite courses of

training can be established and before a sufficient supply of trained candidates is forthcoming, the Ministry of Health hope in due course to be in a position, as a rule, to restrict the grants under their Maternity and Child Welfare Regulations in respect of salaries of health visitors to the cases of those new entrants who have undergone an approved course of training.

(4) It will be understood that these requirements as to training do not apply to voluntary unpaid workers in welfare centres, though of course a high degree of competency and skill in such workers is desirable.

(5) In consultation with the Ministry of Health the Board have prepared the following regulations setting out the conditions under which courses of training for health visitors will be approved. Provision is made for the recognition of two types of course, namely, (*a*) a full course of two years' duration intended for ordinary students, and (*b*) a shortened course of one year's duration for trained nurses and other persons already possessing substantial knowledge or experience. The Board of Education and the Ministry of Health are here concerned only to lay down a minimum standard of training. Many local authorities will doubtless expect their health visitors to possess additional qualifications.

(6) Before considering the type of training required, it is necessary to arrive at a clear conception of the nature and scope of the duties for which the student's course may reasonably be expected to prepare her. Originally, a health visitor was concerned, mainly at any rate, with home visiting and other duties in connection with the welfare of infants and of children under school age. In some areas her duties are still so restricted, but to an increasing extent the health visitor also undertakes other responsible duties such as those of a school nurse or a tuberculosis visitor. This combination of duties is generally to be commended as making for the increased efficiency of the local health services and is likely to become the normal arrangement, though some variation due to the size and circumstances of the area may be expected.

(7) In some areas health visitors are also expected to undertake the inspection and supervision of midwives, or to

discharge certain duties which can only be performed by a midwife or a fully trained nurse. It is not practicable, or indeed necessary, to require that every intending health visitor should include in her course three years' training in nursing. Further, after careful consideration, it has been decided that the course need not include the whole of the syllabus prescribed for the Certificate of the Central Midwives Board. Instruction in the care of maternity and of the newly born child is, of course, essential, and much of the syllabus (other than midwifery proper) for the Certificate will be included in the ordinary course. It should be possible to provide sufficient practical and theoretical instruction in the care of the expectant and nursing mother and even the lying-in woman and of the infant to meet all ordinary requirements. If the health visitor is to undertake special duties connected with midwifery, she will doubtless be required to qualify herself by taking separately the course for the C.M.B. Certificate. There should always be a demand for persons who possess this qualification, as also for persons who are fully trained nurses.

Some County Authorities may desire to continue to arrange for the duties of the health visitor to be discharged, at any rate in the more rural parts of their areas, by district nurses who are not fully qualified nurses. Such persons should, as part of their ordinary training or otherwise, receive some instruction in these duties, but the courses contemplated under these regulations would not normally be suitable for the purpose.

Full Courses.

(8) These courses are designed for persons of 18 years of age and over who do not possess any substantial knowledge or experience of a *special* nature likely to be of value to them in their future work. It is evident that if such students are to obtain any sufficient advantage from their course they must have received a good previous education, preferably a secondary school education, up to the age of 18. It is not proposed for the present, at any rate, to limit admissions to students who have passed certain prescribed examinations, but the Authorities of the Institution will be expected to satisfy themselves in each case that the student's previous

education has been such that she is likely to profit from the course.

The minimum age for admission has been fixed at 18, because it is essential that girls should be able to proceed direct to the course immediately on completing a full course at a secondary school. It has, however, to be recognized that students who enter at this age will only be 20 years of age on the completion of their course, and generally will not be sufficiently experienced or mature at once to take posts of responsibility. Such students will, however, often desire to take a further course of training such as that for the Certificate of the Central Midwives Board, or they may, in the first instance, take posts of limited responsibility in Infant Welfare Centres or elsewhere.

(9) At the present time it is neither practicable nor desirable to indicate in anything more than broad outline the subjects to be included in the course. Institutions will be expected to submit for approval an outline of their scheme of work, together with an estimate of the time to be given to each subject. It is recognized that all proposals will be experimental to begin with, and that some considerable variation may reasonably be allowed.

(10) It is generally agreed that the course should provide for both theoretical instruction and practical training, probably in about equal proportions. The period of training represents the best if not the only opportunity which a student will ordinarily have of obtaining the theoretical knowledge essential for efficient work. On the other hand practical work is required to illustrate and enforce the theoretical instruction. Further, the practical training, while it cannot replace the experience gained through actual work in a responsible position, should at any rate be such as to enable the student to obtain a knowledge and appreciation of sound methods of working.

(11) Article 6 of the Regulations sets out what it is considered should be the principal subjects of instruction. It is desirable to add a few words of explanation in regard to each.

(i) *Elementary Physiology.*—Such instruction provides the only reliable basis for instruction in the other subjects of the course, and its bearing upon them should be con-

stantly emphasized. Subject to this, the nature and extent of the instruction given may to some extent depend on the attainments of the students and the facilities available, but it should normally include:—

The fundamental phenomena of living matter; the cell as the anatomical and physiological unit; outline of chemical and physical principles applicable to living organisms; elementary anatomy and structure of organs of the body; functions of the central nervous system and the sense organs, blood and circulatory system; respiratory, digestive, excretory and reproductive systems.

Exercise and fatigue; regulation of body temperature; protection of body against disease.

Some simple practical work in the laboratory is essential.

(ii) *Methods of Artizan Cookery and Household Management.*—The health visitor need not be a skilled cook, but she should in the course of her visits be competent to advise in regard to dietaries (especially for children), facilities for cooking, household economy and domestic arrangements.

(iii) *Hygiene.*—It is contemplated that the course will include:—

Domestic and personal hygiene; cleanliness; habits; exercise; rest and sleep; clothing.

General hygiene; ventilation and fresh air; heating and lighting; drainage and household sanitation; water; refuse; storage of milk and foods.

It will usually be found desirable to extend the syllabus to cover generally the duties performed by a sanitary inspector, though certain of them will seldom be discharged by a health visitor. In any case there should be instruction on practical points, which must come to the attention of a health visitor, e.g., the suppression of ordinary nuisances, the usual criteria of unwholesome food, the causes and prevention of fly breeding.

(iv) *Infectious and Communicable Diseases.*—It is contemplated that the instruction should deal with such matters as:—

Characteristics; early symptoms; periods of incuba-

tion and infection; mode of spreading; isolation; disinfection;

Parasitic diseases;

Principal legal enactments and regulations;

Local provision for prevention and treatment;

Dispensaries for dealing with tuberculosis and venereal disease; domiciliary and institutional treatment.

(v) *Maternity, Infant and Child Welfare.*—As already explained it is beyond the scope of the course to train midwives or inspectors of midwives. The aim should rather be to give the student such a knowledge of maternity and ante-natal conditions as will enable her to assist the medical officer at consultations and clinics, and to advise the mother as to the carrying out of his instructions. She should also possess such a knowledge of the functions and duties of midwives as will enable her to co-operate with them.

Infant and child welfare should be fully dealt with. The instruction should include such subjects as the following:—

Conditions of health of infants and young children, common ailments, methods of feeding.

The duties of a health visitor.

The functions and organization of maternity and child welfare centres, day nurseries, nursery schools.

Medical inspection of school children, inspection and treatment centres, supervision of ailing and abnormal children.

Methods of giving simple health instruction.

Keeping of records.

Infant mortality and elementary vital statistics.

The principal statutory enactments and regulations.

(vi) *Elementary Economics and Social Problems.*—Health visitors cannot adequately perform their duties unless they appreciate the conditions of life of the children and their parents in the district in which they work. While training alone cannot give the knowledge, it is important by way of preparation that their course should include instruction in local government, modern social and industrial conditions, social legislation, the activities of the chief types of voluntary institutions and agencies.

(12) *Practical Work* should occupy about half of the student's time; it should include visits of inspection to a wide range of Institutions conducted under adequate supervision in order to familiarize the student with different conditions and methods of working. The greater part of the time should, however, be given to continuous attendance at one or two institutions concerned with infant and child welfare. During her attendance the student should take a definite part in the daily work; her time will be largely wasted if she is nothing more than an onlooker. The time so spent should be not less than four months and should ordinarily be more. It is likely that in the majority of cases the whole of the period will be spent in infant welfare centres and school treatment clinics. Where practicable, however, arrangements should be made for students to spend a part of the period in a maternity hospital or children's hospital, a children's observation ward, a day nursery or other similar institution. Such an arrangement should provide the student with a valuable experience which she could hardly otherwise obtain. On the other hand it may present certain difficulties in practice. The number of suitable institutions is limited; and where they exist it is not always easy to arrange for the student to participate in the work of the institution, or to be instructed in the reasons underlying its practice and routine. Unless the principal institutions attended provide the requisite facilities, the students should also attend for continuous periods at a maternity centre and a tuberculosis dispensary.

In addition not less than two months should be given to practical work in Elementary Economics and Social Problems.

Shortened Courses.

(13) Though many of the recruits for the profession may be drawn from persons who have taken a two years' course of training, it may be anticipated that there will be a number of fully-trained nurses who for one reason or another desire to take up this class of work. In view of the training which they have already received they should not require to take the whole of the full course. In particular, it should be possible substantially to reduce their practical work. The regulations also provide for the admission to a one-year course of train-

ing of students who have already worked as health visitors for a period of not less than three years. The greater part of their course should as a rule be devoted to theoretical instruction.

(14) There may also be a certain number of women who, after taking a degree course at a University, are desirous of taking up work as health visitors and who are likely to prove valuable recruits. Such persons may not be prepared to undergo two years of further training, nor, in view of their previous education, should it often be necessary for them to do so. The course likely to be best suited to their needs will to some extent depend on the nature of their previous attainments and experience.

Recognized Institutions.

(15) No courses of training will be recognized unless the Institution is in a position effectively to control the whole of the student's course. The regulations provide that courses of training will as a rule only be recognized if they are conducted by, or in close association with, a University Institution. It is under such conditions that the requisite standard of theoretical instruction is most likely to be obtained, and adequate facilities for practical work secured. A University institution also affords exceptional opportunities for free intercourse with other classes of students, a matter of perhaps special importance to future health visitors.

Examinations and Diplomas.

(16) Every student will be expected before the completion of her course of training to take an approved examination in the subjects of her course. The primary purpose of the examination will be to test the extent to which the student has benefited by her course. It will be partly written and partly oral. In considering the results of the examination, regard must be had to records of the student's training. The examination will ordinarily be held at the end of the course, but in special circumstances part of the written examination may be taken at an earlier stage. The regulations contemplate that the examination will be conducted not by the Board of Education but by a special examining body approved for the purpose. At any rate to begin with it will promote

uniformity of standard, if recognized institutions combine to establish a joint examining body. Except in the case of a University the Board would not approve a proposal for an institution to examine their own students. It will be a condition of the Board's approval that provision is made for one or more of their officers to act as assessors.

(17) Under conditions to be sanctioned by the Board the authorities of an approved institution or an approved examining body may issue a diploma to a student who has completed an approved course of training and passed her examination. The diploma will state the name of the institution at which she was trained and the length of her course of training. It may also state any subject in which she has passed with credit.

Grants.

(18) Article 11 of the Regulations provides for the payment of annual grants to the authorities of institutions in aid of the training and instruction of students in approved courses. The total grant payable on account of a student will be £40 for a full course and £20 for a shortened course. Grants may be paid by instalments. Grants will first be payable for the session commencing August 1, 1919.

I.—*General.*

THE BOARD OF EDUCATION (HEALTH VISITORS' TRAINING REGULATIONS, 1919, DATED SEPTEMBER 13, 1919, MADE BY THE BOARD OF EDUCATION UNDER SECTION 44 OF THE EDUCATION ACT, 1918 (8 and 9 GEO. 5 c. 39) FOR THE TRAINING OF HEALTH VISITORS (INCLUDING REGULATIONS FOR PAYMENT OF GRANT IN RESPECT OF SUCH TRAINING).

The Board of Education hereby make the following Regulations:—

1.—(*a*) The Board of Education will, subject to the conditions of these Regulations, give grants in aid of recognized courses of training designed for persons who desire employment as health visitors.

(*b*) For the purpose of these Regulations, the work of a health visitor is to be regarded as including, in addition to home visiting, work in connection with maternity and child

welfare, with the school medical service (including attendance at a school clinic), with tuberculosis (including attendance at a dispensary) and with domestic sanitation.

It is not regarded as including the work of a midwife, the inspection of midwives or district nursing.

2.—(*a*) Courses will, as a rule, only be recognized if they are conducted by, or in close association with, a university institution.

(*b*) The institution providing the course must be responsible to the Board for the whole of the arrangements, which must be such as to provide adequate and suitable facilities for both theoretical instruction and practical training.

(*c*) The whole of the arrangements must be open at all times to the inspectors or other authorized officers of the Board.

3.—The academic year will be regarded as commencing on August 1 ; but with the special sanction of the Board students may be admitted to courses commencing as from January 1, or April 1.

4.—Schemes of instruction and training should be submitted beforehand for the approval of the Board. They may provide for (*a*) full courses ; (*b*) shortened courses.

II.—*Full Courses.*

5.—(*a*) A full course will be of two years' duration.

(*b*) A student will not be eligible for admission to the course unless she satisfies the authorities of the institution that—

(i) she is over 18 years of age at the date of the commencement of the course ;

(ii) her previous education has been such that she is likely to profit by the course.

6.—(*a*) The course must provide for both theoretical instruction and practical training in about equal proportions.

(*b*) The theoretical instruction should include instruction in—

(i) Elementary physiology, and the structure of the body.

(ii) Methods of artisan cookery and household management.

(iii) Hygiene.

(iv) Infectious and communicable diseases.

(v) Maternity, infant and child welfare.

(vi) Elementary economics and social problems.

(*c*) The practical training must be designed to illustrate the theoretical instruction, and to give the students a first-hand personal knowledge of the various aspects of their future work.

III.—*Shortened Courses.*

7.—(*a*) A shortened course will be of one year's duration, and is intended for students who already possess substantial knowledge or experience likely to be of assistance to them in their profession.

(*b*) No student may, as a rule, be admitted to a shortened course unless—

(i) she is a hospital nurse who has completed a three years' course of training at a recognized training school for nurses; or

(ii) she has spent not less than three years in full-time employment as a health visitor in one or other of the capacities mentioned in Article 1 (*b*); or

(iii) she has obtained a university degree or its equivalent.

(*c*) Students must satisfy the authorities of the institution that they possess knowledge or experience likely to enable them to undertake a shortened course with profit.

8.—A shortened course should provide for both theoretical instruction and practical training in the subjects named in Article 6, subject to such curtailments as may be justified, regard being had to the previous knowledge and experience of the students.

IV.—*Examinations and Diplomas.*

9.—(*a*) Every student will be required to enter for an approved examination before the end of her course of training. No student will be regarded as having completed her course of training satisfactorily unless she passes the examination.

(*b*) The examination will include the subjects named in Article 6. It will be partly written and partly oral. In determining whether a student can be considered as having passed the examination regard must be had to records of the student's training.

(*c*) The examination will be conducted by an examining body approved by the Board. It will be a condition of the Board's approval that provision is made for one or more of their officers to act as assessors.

(*d*) If a student fails to pass the examination before the completion of her course, she may be allowed to re-enter for the examination under such conditions as may be approved by the Board.

10.—The authorities of the institution or the examining body may, under conditions sanctioned by the Board, issue to a student a diploma certifying that she has passed the examination and that she has satisfactorily completed a course of training approved by the Board. The diploma may state the name of the institution at which she was trained and the length of her course. It may also state any subject in which she passed with credit.

V.—*Grants.*

11.—(*a*) Grant will be payable to the authorities of the institution for each academical year. It will be payable at the rate of £20 for each student.

(*b*) If a student attends during a part of the year only, the Board may pay the grant in full or may pay such portion of the grant as they think fit; but the total grant payable for a student will not exceed £40, for a full course, or £20 for a shortened course.

12.—Instalments of grant may be paid terminally, and may be based on the number of students in attendance at the beginning of the academical year. The balance of the grant will be paid after the end of the academical year.

13.—The payment of grant and the continuance of recognition is subject to the fulfilment of the conditions laid down in these Regulations, but if any of the conditions have not been fulfilled the Board may, nevertheless, where there are special circumstances which would justify it, pay such grant as they may think fit instead of withdrawing recognition or as a preliminary to so doing.

14.—The authorities of the institution shall keep such records and make such returns as may from time to time be required by the Board.

15—If any question arises as to the interpretation of these Regulations the decision of the Board shall be final.

16.—These Regulations may be cited as "The Board of Education (Health Visitors' Training) Regulations, 1919."

Given under the Seal of Office of the Board of Education this 13th day of September, 1919, and laid before Parliament pursuant to Section 44 (6) of the Education Act, 1918.

(L.S.) L. A. SELBY-BIGGE,
Secretary to the Board of Education.

APPENDIX III.

THE HEALTH VISITORS (LONDON) ORDER, 1909, DATED SEPTEMBER 4, 1909.

Qualification.

Article I.—(1) A woman shall be qualified to be appointed a health visitor if she

(*a*) Is a duly qualified medical practitioner within the meaning of the Medical Acts; or

(*b*) Is qualified for the appointment of nurse by having undergone, for three years at least, a course of instuction in the medical and surgical wards of any hospital or infirmary, being a training school for nurses, and having a resident physician or house surgeon; or

(*c*) is certified under the Midwives Act, 1902; or

(*d*) Has, for a period of not less than six months, undergone in a hospital or infirmary, receiving children as well as adults, and having a resident physician or house surgeon, a course of instruction including subjects relating to personal hygiene, and holds the certificate of the Royal Sanitary Institute for Health Visitors and School Nurses, or the certificate or diploma of the National Health Society, or of any other body which may from time to time be approved by us; or

(*e*) Has, in the service of a Sanitary Authority, or of the Council of a Borough or of another Urban District or of any other Public Body or Authority in England or Wales, discharged duties which, in our opinion, are

similar to those described in the Act or prescribed by these Regulations in relation to the office of Health Visitor, and produces such evidence as, in our opinion, suffices to prove her competency.

(2) Where, in our opinion, the circumstances so require, the Sanitary Authority may, with our consent, and subject to such conditions as we impose, appoint to the office of health visitor a woman who, though not possessing any such qualification as is prescribed by sub-division (1) of this Article, has a competent knowledge and experience of the theory and practice of nurture, of the care and management of young children, of attendance on women in and immediately after childbirth, and of nursing attendance in cases of sickness or other mental and bodily infirmity.

Appointment.

Article II.—(1) The Sanitary Authority who propose to make an appointment to the office of health visitor shall, after their selection of the woman whom they propose to appoint, furnish us in writing with a statement comprising the name of the woman selected, the particulars of her qualification, a description of the district for which it is proposed that she shall be appointed, the amount of salary proposed to be assigned to the office, and such other details as, in relation to the proposed appointment, are from time to time required by us, and, except where we, by reason of special circumstances in any particular case, confirm an appointment made without our previous approval of the selection of the woman to be appointed, no appointment shall be valid until the selection of the woman to be appointed has been approved by us.

(2) The Sanitary Authority who propose to make an appointment to the office of health visitor, and who have ascertained that no woman seeking, or proposed for, the appointment, possesses any such qualification as is prescribed by sub-division (1) of Article I. of these Regulations shall, before their selection of the woman whom they propose to appoint, cause to be inserted once at least in one or more of the newspapers circulating in the metropolitan borough or other area for which the sanitary authority act, and so that

a period of not less than seven days shall elapse after the date of the insertion, or of the first insertion, as the case may be, and before the day fixed for the selection, an advertisement specifying the metropolitan borough or other area and the district within that metropolitan borough or area for which the selection is to be made, together with the amount of salary proposed to be assigned, and the day on or before which the application in writing of any woman seeking the appointment must be sent to the clerk to the Sanitary Authority.

Article III.—When we have approved the selection of the woman to be appointed, the Sanitary Authority shall proceed to the appointment of the woman so selected to the office of health visitor.

Article IV.—Every selection and appointment of a woman to the office of health visitor shall be made by a majority of the members present and voting on the question at a meeting of the Sanitary Authority.

Article V.—Every appointment shall, within seven days after it is made, be reported to us by the clerk to the Sanitary Authority.

Tenure of Office.

Article VI.—The appointment of a health visitor may at any time be determined by the Sanitary Authority by giving her three months' notice in writing of their intention to do so, and no woman shall be appointed to the office of health visitor who does not agree to give three months' notice previous to resigning the office, or to forfeit such sum as may be agreed upon as liquidated damages:

Provided as follows:—

(1) The appointment of a health visitor may be determined by the Sanitary Authority, with our consent, for any reason which we deem sufficient, at any time before the expiration of any notice given by the Sanitary Authority as aforesaid;

(2) The appointment of a health visitor may also be determined by us if at any time it appears to us to be desirable that she should cease to discharge the duties of her office.

Article VII.—The Sanitary Authority may, at their dis-

cretion, suspend any health visitor from the discharge of her duties. The suspension may be removed by the Sanitary Authority, and in that case the health visitor shall forthwith resume the performance of her duties.

Duties.

Article VIII.—In addition to the duties specified in the Act as the purpose for which a health visitor may be appointed, the duties of every health visitor shall be as follows: that is to say—

(1) The health visitor shall, in relation to each person visited, enter on a suitable card or in a book to be called "the Health Visitor's Report Book" all such particulars as the Sanitary Authority or the Medical Officer of Health require to be ascertained and recorded, and shall submit the cards or "Health Visitor's Report Book" to the Sanitary Authority or the Medical Officer of Health so often and at such times as may be required, and, subject to the directions of the Medical Officer of Health, shall keep the cards arranged so that any card may be readily available for reference at any time when the card is not in use for the purpose of a visit.

(2) The health visitor shall, under the direction of the Medical Officer of Health, discharge such duties, not being duties of a Sanitary Inspector, as may be assigned to her by the Sanitary Authority in connection with and for the purposes of the administration by the Sanitary Authority of any public and general Act or local and personal Act under which powers are conferred or duties are imposed upon the Sanitary Authority with respect to matters relating to public health, the housing of the working classes, and the notification of births, or of any by-laws or regulations made under any such Act.

(3) The health visitor shall discharge such duties in substitution for, or in addition to, any duties assigned to her under the paragraph numbered (2) in this article in connection with any of the acts, by-laws or regulations mentioned in that paragraph, or in connection with other acts, by-laws or regulations as may be prescribed by us, whether generally, by further regulations made by us in

pursuance of the Act, or, in the case of any particular health visitor, by an instrument issued by us in that behalf under Our Hand and Seal.

(4) The health visitor shall observe and execute, in regard to matters not specifically provided for in this Order, any such instruction issued by us and any such order or direction of the Sanitary Authority or the Medical Officer of Health as may be applicable to her office.

APPENDIX IV.

Maternity and Child Welfare.

Qualifications of Health Visitors.

(*Local Government Board Circular, August 9th*, 1918.)

(14) Other offices, such as that of Tuberculosis Nurse, School Nurse and Mental Deficiency Visitor, may be held with that of Health Visitor in certain cases, so as to give the officer a compact district, save the time and money spent in travelling, and reduce the number of inspectors who may have to visit a particular house. The salary of a whole-time officer acting as health visitor with or without these other posts should as a rule be not less than £120 a year.

District Nurses as Health Visitors.

(15) In sparsely populated districts it may be convenient to appoint the district nurse-midwives of Nursing Associations as Health Visitors, if the Medical Officer of Health is satisfied that they are competent to perform the work. In some cases it may be found practicable to give the nurse-midwives special instruction and training in the work of a Health Visitor. More than half the County Councils are now using district nurse-midwives as Health Visitors. The advantages of employing them are that, as a rule, they are well known and well received by the women in a country parish, that their advice is readily accepted, and that the arrangement

may obviate duplication of inspection, and save time and money spent in travelling.

(16) Where nurse-midwives employed by associations affiliated to the County Nursing Asoociation are employed as health visitors, the County Council and the County Nursing Association may find it advantageous to combine the offices of Superintendent of the County Nursing Association, Chief Health Visitor and Inspector of Midwives, so that the nurse-midwives are inspected by one official in all capacities.

Visiting by Voluntary Workers.

(17) In a few districts voluntary workers, generally without full training, engage in health visiting. Their work should always be done in connection with that of trained and paid officers and they may usefully assist at the Centres and in the supervision of older children.

APPENDIX V.

(A)—Apparatus Required for Ante-natal Clinic.

Urine testing apparatus.
Pelvimeter.
Catheter.
Vaginal specula—three sizes.
Playfair's probe.
Polypus forceps.
Kidney bowls—two.
Rubber gloves.
Sterilizer.
Cotton wool.
Fœtal stethoscope.

(Front)

(B)—Inquiry Infant and Child Consultations.

Name.....Address .....

Sex.....Date of birth..... .....Weight at birth .....

Date of first attendance.....Character of labour.....

Family history...	Other children alive (health).....Miscarriages .....
	Dead (cause).....Still-births .....
	Parents—Father (health, age and occupation) .....
	Mother (health, teeth, nutrition, physique, vigour and age) .....
	Occupation of mother (before marriage) .....
	(after marriage) .....
Personal history	Health from birth to present time, illness, especially infectious, with dates.....
	Age when first talked .....Age when first walked...
	Method of feeding .....
Habits of child...	Sleep.....Airing.....
	Nerves .....Dummy .....
	Bath .....Clothing.....
Present condition	Height .....General health .....
	Development .....Teeth .....
	Nasopharynx .....Eyes and Ears .....
	Bony system (rickets) .....Lungs.....
	Genito-urinary system..... Heart, &c.....
	Abdomen (bowels) .....Skin .....
	Umbilicus.....Glands .....
	Intelligence.....

(Back)

Name .....Date of birth.....

Date	Weight	Diet	Age of child	Remarks as to progress	Teeth	Recommendations

The Editor wishes to express her gratitude to Dr. Bond, the Medical Officer of Health for Holborn, for his permission to reproduce the Birth Inquiry, Infant Mortality and Clinic Inquiry forms as used at Holborn.

APPENDIX VI.

Headings in Infant Mortality Records.

No.	Date of death	Name and occupation of father	Address	Illegitimate	Sex	Age	Cause of death	Method of feeding	Occupation of mother	Number of rooms	Number in family	Heredity	Remarks

APPENDIX VII.

(Face.)

Birth Card.

(N.B.—Exact dimensions, 6 in. by 4 in.)

Birth. Registered.....
Date of 1st Visit .....

Address.....Floor
Name $\frac{M}{F}$.....
Date of Birth.....Legit.....
Attended by Doctor, Midwife, Student of Hospital.....
Condition of Child at Birth.....Now.....
How fed.....
Type of Bottle.....Clean.....
Milk Supply.....Boiled.....
Cot used.....Child in charge of.....
Occupation of Father.....of Mother.....
Habits of Mother .....
No. in Family $\frac{A}{10}$.....$\frac{10}{C}$.....No. of rooms .....Condition.....
Condition of Premises.....
Remarks (Hereditary illness, &c.) .....
.....

(Back.)

Previous Children Stillborn Dead Alive
Ditto How fed.....
.....
Ages and Conditions of Living.....
.....

Further Visits, Dates when any change of Feeding, &c.:

Date	

APPENDIX VIII. (A).

(Face.)

TUBERCULOSIS VISITING.

MARRIED or SINGLE NOTIFICATION

NAME..... AGE..... Children { Date of.....M.O.H. No.
Nationality.....

Insurance

ADDRESS .....

No. of Rooms..... Occupation.....

Rent..... Earnings.....

PATIENT'S CONDITION—

Duration of Illness, Symptoms, Habits, &c. ...

FAMILY HISTORY—

Probable Source of Infection; Home; Work; House ... ...

HOUSING CONDITIONS—

Type, General Aspect, Situation of Rooms, Ventilation, Windows, Damp, Dirty, Clean, Light, &c.

LENGTH OF RESIDENCE—

PRECAUTIONS—

Sleeping, Open Windows, Sputum, Handkerchiefs, &c. ... ...

FORMER ADDRESSES—

REPORT ANY CONTACT CASE ... ...

NOTES—

HOSPITALS, &C., ATTENDED.

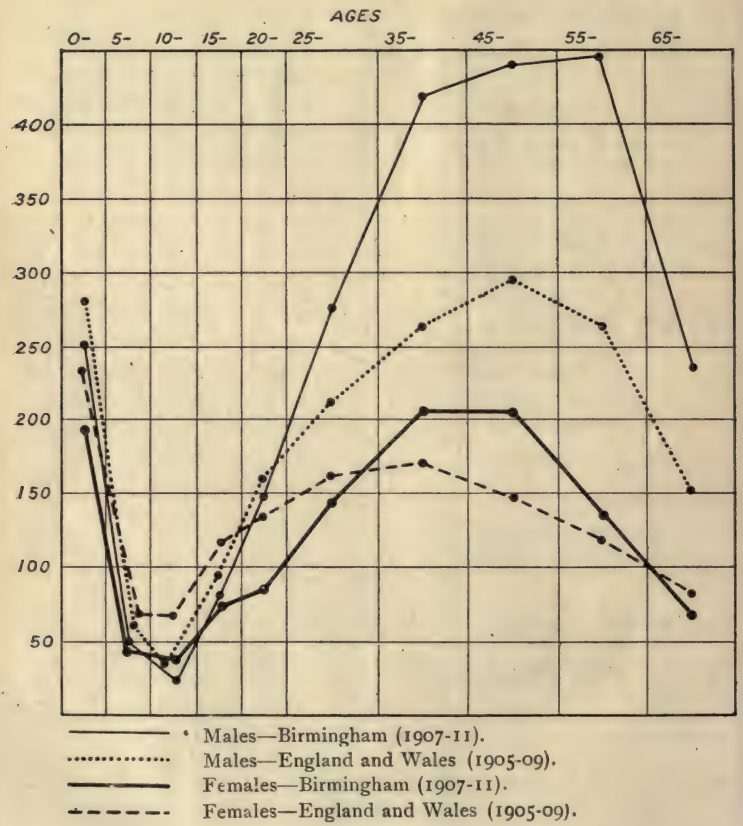
(Back

VISITS

DATE

APPENDIX VIII. (B.)

DEATH RATES FROM TUBERCULOSIS (ALL FORMS) PER 100,000 LIVING AT VARIOUS AGE PERIODS.



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